

113TH CONGRESS
2D SESSION

H. R. 4302

IN THE SENATE OF THE UNITED STATES

MARCH 27, 2014

Received

AN ACT

To amend the Social Security Act to extend Medicare payments to physicians and other provisions of the Medicare and Medicaid programs, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) SHORT TITLE.—This Act may be cited as the
3 “Protecting Access to Medicare Act of 2014”.

4 (b) TABLE OF CONTENTS.—The table of contents of
5 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—MEDICARE EXTENDERS

- Sec. 101. Physician payment update.
- Sec. 102. Extension of work GPCI floor.
- Sec. 103. Extension of therapy cap exceptions process.
- Sec. 104. Extension of ambulance add-ons.
- Sec. 105. Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals.
- Sec. 106. Extension of the Medicare-dependent hospital (MDH) program.
- Sec. 107. Extension for specialized Medicare Advantage plans for special needs individuals.
- Sec. 108. Extension of Medicare reasonable cost contracts.
- Sec. 109. Extension of funding for quality measure endorsement, input, and selection.
- Sec. 110. Extension of funding outreach and assistance for low-income programs.
- Sec. 111. Extension of two-midnight rule.
- Sec. 112. Technical changes to Medicare LTCH amendments.

TITLE II—OTHER HEALTH PROVISIONS

- Sec. 201. Extension of the qualifying individual (QI) program.
- Sec. 202. Temporary extension of transitional medical assistance (TMA).
- Sec. 203. Extension of Medicaid and CHIP express lane option.
- Sec. 204. Extension of special diabetes program for type I diabetes and for Indians.
- Sec. 205. Extension of abstinence education.
- Sec. 206. Extension of personal responsibility education program (PREP).
- Sec. 207. Extension of funding for family-to-family health information centers.
- Sec. 208. Extension of health workforce demonstration project for low-income individuals.
- Sec. 209. Extension of maternal, infant, and early childhood home visiting programs.
- Sec. 210. Pediatric quality measures.
- Sec. 211. Delay of effective date for Medicaid amendments relating to beneficiary liability settlements.
- Sec. 212. Delay in transition from ICD–9 TO ICD–10 code sets.
- Sec. 213. Elimination of limitation on deductibles for employer-sponsored health plans.
- Sec. 214. GAO report on the Children’s Hospital Graduate Medical Education Program.
- Sec. 215. Skilled nursing facility value-based purchasing.
- Sec. 216. Improving Medicare policies for clinical diagnostic laboratory tests.

- Sec. 217. Revisions under the Medicare ESRD prospective payment system.
- Sec. 218. Quality incentives for computed tomography diagnostic imaging and promoting evidence-based care.
- Sec. 219. Using funding from Transitional Fund for Sustainable Growth Rate (SGR) Reform.
- Sec. 220. Ensuring accurate valuation of services under the physician fee schedule.
- Sec. 221. Medicaid DSH.
- Sec. 222. Realignment of the Medicare sequester for fiscal year 2024.
- Sec. 223. Demonstration programs to improve community mental health services.
- Sec. 224. Assisted outpatient treatment grant program for individuals with serious mental illness.
- Sec. 225. Exclusion from PAYGO scorecards.

1 **TITLE I—MEDICARE EXTENDERS**

2 **SEC. 101. PHYSICIAN PAYMENT UPDATE.**

3 Section 1848(d) of the Social Security Act (42 U.S.C.
4 1395w–4(d)) is amended—

5 (1) in paragraph (15)—

6 (A) in the heading, by striking “JANUARY
7 THROUGH MARCH OF”;

8 (B) in subparagraph (A), by striking “for
9 the period beginning on January 1, 2014, and
10 ending on March 31, 2014”; and

11 (C) in subparagraph (B)—

12 (i) in the heading, by striking “RE-
13 MAINING PORTION OF 2014 AND”;

14 (ii) by striking “the period beginning
15 on April 1, 2014, and ending on December
16 31, 2014, and for”;

17 (2) by adding at the end the following new
18 paragraph:

1 “(16) UPDATE FOR JANUARY THROUGH MARCH
2 OF 2015.—

3 “(A) IN GENERAL.—Subject to paragraphs
4 (7)(B), (8)(B), (9)(B), (10)(B), (11)(B),
5 (12)(B), (13)(B), (14)(B), and (15)(B), in lieu
6 of the update to the single conversion factor es-
7 tablished in paragraph (1)(C) that would other-
8 wise apply for 2015 for the period beginning on
9 January 1, 2015, and ending on March 31,
10 2015, the update to the single conversion factor
11 shall be 0.0 percent.

12 “(B) NO EFFECT ON COMPUTATION OF
13 CONVERSION FACTOR FOR REMAINING PORTION
14 OF 2015 AND SUBSEQUENT YEARS.—The con-
15 version factor under this subsection shall be
16 computed under paragraph (1)(A) for the pe-
17 riod beginning on April 1, 2015, and ending on
18 December 31, 2015, and for 2016 and subse-
19 quent years as if subparagraph (A) had never
20 applied.”.

21 **SEC. 102. EXTENSION OF WORK GPCI FLOOR.**

22 Section 1848(e)(1)(E) of the Social Security Act (42
23 U.S.C. 1395w-4(e)(1)(E)) is amended by striking “April
24 1, 2014” and inserting “April 1, 2015”.

1 **SEC. 103. EXTENSION OF THERAPY CAP EXCEPTIONS PROC-**
2 **ESS.**

3 Section 1833(g) of the Social Security Act (42 U.S.C.
4 1395l(g)) is amended—

5 (1) in paragraph (5)(A), in the first sentence,
6 by striking “March 31, 2014” and inserting “March
7 31, 2015”; and

8 (2) in paragraph (6)(A)—

9 (A) by striking “March 31, 2014” and in-
10 serting “March 31, 2015”; and

11 (B) by striking “2012, 2013, or the first
12 three months of 2014” and inserting “2012,
13 2013, 2014, or the first three months of 2015”.

14 **SEC. 104. EXTENSION OF AMBULANCE ADD-ONS.**

15 (a) GROUND AMBULANCE.—Section 1834(l)(13)(A)
16 of the Social Security Act (42 U.S.C. 1395m(l)(13)(A))
17 is amended by striking “April 1, 2014” and inserting
18 “April 1, 2015” each place it appears.

19 (b) SUPER RURAL GROUND AMBULANCE.—Section
20 1834(l)(12)(A) of the Social Security Act (42 U.S.C.
21 1395m(l)(12)(A)) is amended, in the first sentence, by
22 striking “April 1, 2014” and inserting “April 1, 2015”.

1 **SEC. 105. EXTENSION OF INCREASED INPATIENT HOSPITAL**
2 **PAYMENT ADJUSTMENT FOR CERTAIN LOW-**
3 **VOLUME HOSPITALS.**

4 Section 1886(d)(12) of the Social Security Act (42
5 U.S.C. 1395ww(d)(12)) is amended—

6 (1) in subparagraph (B), in the matter pre-
7 ceding clause (i), by striking “in the portion of fiscal
8 year 2014 beginning on April 1, 2014, fiscal year
9 2015, and subsequent fiscal years” and inserting “in
10 fiscal year 2015 (beginning on April 1, 2015), fiscal
11 year 2016, and subsequent fiscal years”;

12 (2) in subparagraph (C)(i), by striking “fiscal
13 years 2011, 2012, and 2013, and the portion of fis-
14 cal year 2014 before” and inserting “fiscal years
15 2011 through 2014 and fiscal year 2015 (before
16 April 1, 2015),” each place it appears; and

17 (3) in subparagraph (D), by striking “fiscal
18 years 2011, 2012, and 2013, and the portion of fis-
19 cal year 2014 before April 1, 2014,” and inserting
20 “fiscal years 2011 through 2014 and fiscal year
21 2015 (before April 1, 2015),”.

22 **SEC. 106. EXTENSION OF THE MEDICARE-DEPENDENT HOS-**
23 **PITAL (MDH) PROGRAM.**

24 (a) IN GENERAL.—Section 1886(d)(5)(G) of the So-
25 cial Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amend-
26 ed—

1 (1) in clause (i), by striking “April 1, 2014”
2 and inserting “April 1, 2015”; and

3 (2) in clause (ii)(II), by striking “April 1,
4 2014” and inserting “April 1, 2015”.

5 (b) CONFORMING AMENDMENTS.—

6 (1) EXTENSION OF TARGET AMOUNT.—Section
7 1886(b)(3)(D) of the Social Security Act (42 U.S.C.
8 1395ww(b)(3)(D)) is amended—

9 (A) in the matter preceding clause (i), by
10 striking “April 1, 2014” and inserting “April 1,
11 2015”; and

12 (B) in clause (iv), by striking “through fis-
13 cal year 2013 and the portion of fiscal year
14 2014 before April 1, 2014” and inserting
15 “through fiscal year 2014 and the portion of
16 fiscal year 2015 before April 1, 2015”.

17 (2) PERMITTING HOSPITALS TO DECLINE RE-
18 CLASSIFICATION.—Section 13501(e)(2) of the Omni-
19 bus Budget Reconciliation Act of 1993 (42 U.S.C.
20 1395ww note) is amended by striking “through the
21 first 2 quarters of fiscal year 2014” and inserting
22 “through the first 2 quarters of fiscal year 2015”.

1 **SEC. 107. EXTENSION FOR SPECIALIZED MEDICARE ADVAN-**
 2 **TAGE PLANS FOR SPECIAL NEEDS INDIVID-**
 3 **UALS.**

4 Section 1859(f)(1) of the Social Security Act (42
 5 U.S.C. 1395w-28(f)(1)) is amended by striking “2016”
 6 and inserting “2017”.

7 **SEC. 108. EXTENSION OF MEDICARE REASONABLE COST**
 8 **CONTRACTS.**

9 Section 1876(h)(5)(C)(ii) of the Social Security Act
 10 (42 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the mat-
 11 ter preceding subclause (I), by striking “January 1, 2015”
 12 and inserting “January 1, 2016”.

13 **SEC. 109. EXTENSION OF FUNDING FOR QUALITY MEASURE**
 14 **ENDORSEMENT, INPUT, AND SELECTION.**

15 Section 1890(d) of the Social Security Act (42 U.S.C.
 16 1395aaa(d)) is amended—

17 (1) by inserting “(1)” before “For purposes”;
 18 and

19 (2) by adding at the end the following new
 20 paragraph:

21 “(2) For purposes of carrying out this section and
 22 section 1890A (other than subsections (e) and (f)), the
 23 Secretary shall provide for the transfer, from the Federal
 24 Hospital Insurance Trust Fund under section 1817 and
 25 the Federal Supplementary Medical Insurance Trust
 26 Fund under section 1841, in such proportion as the Sec-

1 retary determines appropriate, to the Centers for Medicare
 2 & Medicaid Services Program Management Account of
 3 \$5,000,000 for fiscal year 2014 and \$15,000,000 for the
 4 first 6 months of fiscal year 2015. Amounts transferred
 5 under the preceding sentence shall remain available until
 6 expended.”.

7 **SEC. 110. EXTENSION OF FUNDING OUTREACH AND ASSIST-**
 8 **ANCE FOR LOW-INCOME PROGRAMS.**

9 (a) **ADDITIONAL FUNDING FOR STATE HEALTH IN-**
 10 **SURANCE PROGRAMS.**—Subsection (a)(1)(B) of section
 11 119 of the Medicare Improvements for Patients and Pro-
 12 viders Act of 2008 (42 U.S.C. 1395b–3 note), as amended
 13 by section 3306 of the Patient Protection and Affordable
 14 Care Act Public Law 111–148), section 610 of the Amer-
 15 ican Taxpayer Relief Act of 2012 (Public Law 112–240),
 16 and section 1110 of the Pathway for SGR Reform Act
 17 of 2013 (Public Law 113–67), is amended—

18 (1) in clause (iii), by striking “and” at the end;

19 (2) by striking clause (iv); and

20 (3) by adding at the end the following new
 21 clauses:

22 “(iv) for fiscal year 2014, of
 23 \$7,500,000; and

1 “(v) for the portion of fiscal year
2 2015 before April 1, 2015, of
3 \$3,750,000.”.

4 (b) ADDITIONAL FUNDING FOR AREA AGENCIES ON
5 AGING.—Subsection (b)(1)(B) of such section 119, as so
6 amended, is amended—

7 (1) in clause (iii), by striking “and” at the end;

8 (2) by striking clause (iv); and

9 (3) by inserting after clause (iii) the following
10 new clauses:

11 “(iv) for fiscal year 2014, of
12 \$7,500,000; and

13 “(v) for the portion of fiscal year
14 2015 before April 1, 2015, of
15 \$3,750,000.”.

16 (c) ADDITIONAL FUNDING FOR AGING AND DIS-
17 ABILITY RESOURCE CENTERS.—Subsection (c)(1)(B) of
18 such section 119, as so amended, is amended—

19 (1) in clause (iii), by striking “and” at the end;

20 (2) by striking clause (iv); and

21 (3) by inserting after clause (iii) the following
22 new clauses:

23 “(iv) for fiscal year 2014, of
24 \$5,000,000; and

1 “(v) for the portion of fiscal year
2 2015 before April 1, 2015, of
3 \$2,500,000.”.

4 (d) ADDITIONAL FUNDING FOR CONTRACT WITH
5 THE NATIONAL CENTER FOR BENEFITS AND OUTREACH
6 ENROLLMENT.—Subsection (d)(2) of such section 119, as
7 so amended, is amended—

8 (1) in clause (iii), by striking “and” at the end;

9 (2) by striking clause (iv); and

10 (3) by inserting after clause (iii) the following
11 new clauses:

12 “(iv) for fiscal year 2014, of
13 \$5,000,000; and

14 “(v) for the portion of fiscal year
15 2015 before April 1, 2015, of
16 \$2,500,000.”.

17 **SEC. 111. EXTENSION OF TWO-MIDNIGHT RULE.**

18 (a) CONTINUATION OF CERTAIN MEDICAL REVIEW
19 ACTIVITIES.—The Secretary of Health and Human Serv-
20 ices may continue medical review activities described in
21 the notice entitled “Selecting Hospital Claims for Patient
22 Status Reviews: Admissions On or After October 1,
23 2013”, posted on the Internet website of the Centers for
24 Medicare & Medicaid Services, through the first 6 months

1 of fiscal year 2015 for such additional hospital claims as
2 the Secretary determines appropriate.

3 (b) LIMITATION.—The Secretary of Health and
4 Human Services shall not conduct patient status reviews
5 (as described in such notice) on a post-payment review
6 basis through recovery audit contractors under section
7 1893(h) of the Social Security Act (42 U.S.C.
8 1395ddd(h)) for inpatient claims with dates of admission
9 October 1, 2013, through March 31, 2015, unless there
10 is evidence of systematic gaming, fraud, abuse, or delays
11 in the provision of care by a provider of services (as de-
12 fined in section 1861(u) of such Act (42 U.S.C.
13 1395x(u))).

14 **SEC. 112. TECHNICAL CHANGES TO MEDICARE LTCH**
15 **AMENDMENTS.**

16 (a) IN GENERAL.—Subclauses (I) and (II) of section
17 1886(m)(6)(C)(iv) of the Social Security Act (42 U.S.C.
18 1395ww(m)(6)(C)(iv)) are each amended by striking “dis-
19 charges” and inserting “Medicare fee-for-service dis-
20 charges”.

21 (b) MMSEA CORRECTION.—Section 114(d) of the
22 Medicare, Medicaid, and SCHIP Extension Act of 2007
23 (42 U.S.C. 1395ww note), as amended by sections 3106(b)
24 and 10312(b) of Public Law 111–148 and by section

1 1206(b)(2) of the Pathway for SGR Reform Act of 2013
2 (division B of Public Law 113–67), is amended—

3 (1) in paragraph (1), in the matter preceding
4 subparagraph (A), by striking “January 1, 2015,”
5 and inserting “on the date of the enactment of para-
6 graph (7) of this subsection”;

7 (2) in paragraph (6), by striking “January 1,
8 2015,” and inserting “on the date of the enactment
9 of paragraph (7) of this subsection”; and

10 (3) by adding at the end the following new
11 paragraph:

12 “(7) ADDITIONAL EXCEPTION FOR CERTAIN
13 LONG-TERM CARE HOSPITALS.—The moratorium
14 under paragraph (1)(A) shall not apply to a long-
15 term care hospital that—

16 “(A) began its qualifying period for pay-
17 ment as a long-term care hospital under section
18 412.23(e) of title 42, Code of Federal Regula-
19 tions, on or before the date of enactment of this
20 paragraph;

21 “(B) has a binding written agreement as
22 of the date of the enactment of this paragraph
23 with an outside, unrelated party for the actual
24 construction, renovation, lease, or demolition
25 for a long-term care hospital, and has ex-

1 pended, before such date of enactment, at least
2 10 percent of the estimated cost of the project
3 (or, if less, \$2,500,000); or

4 “(C) has obtained an approved certificate
5 of need in a State where one is required on or
6 before such date of enactment.”.

7 (c) ADDITIONAL AMENDMENTS.—Section 1206(a) of
8 the Pathway for SGR Reform Act of 2013 (division B of
9 Public Law 113–67) is amended—

10 (1) in paragraph (2)(A), by striking “Assess-
11 ment” and inserting “Advisory”; and

12 (2) in paragraph (3)(B), by striking “shall not
13 apply to a hospital that is classified as of December
14 10, 2013, as a subsection (d) hospital (as defined in
15 section 1886(d)(1)(B) of the Social Security Act, 42
16 U.S.C. 1395ww(d)(1)(B))” and inserting “shall only
17 apply to a hospital that is classified as of December
18 10, 2013, as a long-term care hospital (as defined
19 in section 1861(ccc) of the Social Security Act, 42
20 U.S.C. 1395x(ccc))”.

21 (d) EFFECTIVE DATE.—The amendments made by
22 this section are effective as of the date of the enactment
23 of this Act.

**TITLE II—OTHER HEALTH
PROVISIONS**

**SEC. 201. EXTENSION OF THE QUALIFYING INDIVIDUAL (QI)
PROGRAM.**

(a) EXTENSION.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended by striking “March 2014” and inserting “March 2015”.

(b) EXTENDING TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—Section 1933(g) of the Social Security Act (42 U.S.C. 1396u–3(g)) is amended—

(1) in paragraph (2)—

(A) in subparagraph (T), by striking “and” at the end;

(B) in subparagraph (U)—

(i) by striking “March 31, 2014” and inserting “September 30, 2014”; and

(ii) by striking “\$200,000,000.” and inserting “\$485,000,000;” and

(C) by adding at the end the following new subparagraphs:

“(V) for the period that begins on October 1, 2014, and ends on December 31, 2014, the total allocation amount is \$300,000,000; and

1 “(W) for the period that begins on Janu-
 2 ary 1, 2015, and ends on March 31, 2015, the
 3 total allocation amount is \$250,000,000.”; and
 4 (2) in paragraph (3), in the matter preceding
 5 subparagraph (A), by striking “or (T)” and insert-
 6 ing “(T), or (V)”.

7 **SEC. 202. TEMPORARY EXTENSION OF TRANSITIONAL MED-**
 8 **ICAL ASSISTANCE (TMA).**

9 Sections 1902(e)(1)(B) and 1925(f) of the Social Se-
 10 curity Act (42 U.S.C. 1396a(e)(1)(B), 1396r–6(f)) are
 11 each amended by striking “March 31, 2014” and inserting
 12 “March 31, 2015”.

13 **SEC. 203. EXTENSION OF MEDICAID AND CHIP EXPRESS**
 14 **LANE OPTION.**

15 Section 1902(e)(13)(I) of the Social Security Act (42
 16 U.S.C. 1396a(e)(13)(I)) is amended by striking “Sep-
 17 tember 30, 2014” and inserting “September 30, 2015”.

18 **SEC. 204. EXTENSION OF SPECIAL DIABETES PROGRAM**
 19 **FOR TYPE I DIABETES AND FOR INDIANS.**

20 (a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIA-
 21 BETES.—Section 330B(b)(2)(C) of the Public Health
 22 Service Act (42 U.S.C. 254c–2(b)(2)(C)) is amended by
 23 striking “2014” and inserting “2015”.

24 (b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—
 25 Section 330C(c)(2)(C) of the Public Health Service Act

1 (42 U.S.C. 254c-3(c)(2)(C)) is amended by striking
2 “2014” and inserting “2015”.

3 **SEC. 205. EXTENSION OF ABSTINENCE EDUCATION.**

4 Subsections (a) and (d) of section 510 of the Social
5 Security Act (42 U.S.C. 710) are each amended by strik-
6 ing “2014” and inserting “2015”.

7 **SEC. 206. EXTENSION OF PERSONAL RESPONSIBILITY EDU-**
8 **CATION PROGRAM (PREP).**

9 Section 513 of the Social Security Act (42 U.S.C.
10 713) is amended—

11 (1) in paragraphs (1)(A) and (4)(A) of sub-
12 section (a), by striking “2014” and inserting
13 “2015” each place it appears;

14 (2) in subsection (a)(4)(B)(i), by striking “and
15 2014” and inserting “2014, and 2015”; and

16 (3) in subsection (f), by striking “2014” and
17 inserting “2015”.

18 **SEC. 207. EXTENSION OF FUNDING FOR FAMILY-TO-FAMILY**
19 **HEALTH INFORMATION CENTERS.**

20 Section 501(c)(1)(A) of the Social Security Act (42
21 U.S.C. 701(c)(1)(A)) is amended—

22 (1) in clause (iii), by striking at the end “and”;

23 (2) in clause (iv), by striking the period at the
24 end and inserting a semicolon and by moving the
25 margin to align with the margin for clause (iii); and

1 (3) by adding at the end the following new
2 clauses:

3 “(v) \$2,500,000 for the portion of fiscal year
4 2014 on or after April 1, 2014; and

5 “(vi) \$2,500,000 for the portion of fiscal year
6 2015 before April 1, 2015.”.

7 **SEC. 208. EXTENSION OF HEALTH WORKFORCE DEM-**
8 **ONSTRATION PROJECT FOR LOW-INCOME IN-**
9 **DIVIDUALS.**

10 Section 2008(c)(1) of the Social Security Act (42
11 U.S.C. 1397g(c)(1)) is amended by striking “2014” and
12 inserting “2015”.

13 **SEC. 209. EXTENSION OF MATERNAL, INFANT, AND EARLY**
14 **CHILDHOOD HOME VISITING PROGRAMS.**

15 Section 511(j) of the Social Security Act (42 U.S.C.
16 711(j)) is amended—

17 (1) in paragraph (1)—

18 (A) by striking “and” at the end of sub-
19 paragraph (D);

20 (B) by striking the period at the end of
21 subparagraph (E) and inserting “; and”; and

22 (C) by adding at the end the following new
23 subparagraph:

24 “(F) for the period beginning on October
25 1, 2014, and ending on March 31, 2015, an

1 amount equal to the amount provided in sub-
2 paragraph (E).”; and

3 (2) in paragraphs (2) and (3), by inserting “(or
4 portion of a fiscal year)” after “for a fiscal year”
5 each place it appears.

6 **SEC. 210. PEDIATRIC QUALITY MEASURES.**

7 (a) CONTINUATION OF FUNDING FOR PEDIATRIC
8 QUALITY MEASURES FOR IMPROVING THE QUALITY OF
9 CHILDREN’S HEALTH CARE.—Section 1139B(e) of the
10 Social Security Act (42 U.S.C. 1320b–9b(e)) is amended
11 by adding at the end the following: “Of the funds appro-
12 priated under this subsection, not less than \$15,000,000
13 shall be used to carry out section 1139A(b).”.

14 (b) ELIMINATION OF RESTRICTION ON MEDICAID
15 QUALITY MEASUREMENT PROGRAM.—Section
16 1139B(b)(5)(A) of the Social Security Act (42 U.S.C.
17 1320b–9b(b)(5)(A)) is amended by striking “The aggre-
18 gate amount awarded by the Secretary for grants and con-
19 tracts for the development, testing, and validation of
20 emerging and innovative evidence-based measures under
21 such program shall equal the aggregate amount awarded
22 by the Secretary for grants under section
23 1139A(b)(4)(A)”.

1 **SEC. 211. DELAY OF EFFECTIVE DATE FOR MEDICAID**
2 **AMENDMENTS RELATING TO BENEFICIARY**
3 **LIABILITY SETTLEMENTS.**

4 Effective as if included in the enactment of the Bipar-
5 tisan Budget Act of 2013 (Public Law 113–67), section
6 202(c) of such Act is amended by striking “October 1,
7 2014” and inserting “October 1, 2016”.

8 **SEC. 212. DELAY IN TRANSITION FROM ICD–9 TO ICD–10**
9 **CODE SETS.**

10 The Secretary of Health and Human Services may
11 not, prior to October 1, 2015, adopt ICD–10 code sets
12 as the standard for code sets under section 1173(c) of the
13 Social Security Act (42 U.S.C. 1320d–2(c)) and section
14 162.1002 of title 45, Code of Federal Regulations.

15 **SEC. 213. ELIMINATION OF LIMITATION ON DEDUCTIBLES**
16 **FOR EMPLOYER-SPONSORED HEALTH PLANS.**

17 (a) IN GENERAL.—Section 1302(c) of the Patient
18 Protection and Affordable Care Act (Public Law 111–148;
19 42 U.S.C. 18022(c)) is amended—

20 (1) by striking paragraph (2); and

21 (2) in paragraph (4)(A), by striking “para-
22 graphs (1)(B)(i) and (2)(B)(i)” and inserting “para-
23 graph (1)(B)(i)”.

24 (b) CONFORMING AMENDMENT.—Section 2707(b) of
25 the Public Health Service Act (42 U.S.C. 300gg–6(b)) is

1 amended by striking “paragraphs (1) and (2)” and insert-
2 ing “paragraph (1)”.

3 (c) EFFECTIVE DATE.—The amendments made by
4 this Act shall be effective as if included in the enactment
5 of the Patient Protection and Affordable Care Act (Public
6 Law 111–148).

7 **SEC. 214. GAO REPORT ON THE CHILDREN’S HOSPITAL**
8 **GRADUATE MEDICAL EDUCATION PROGRAM.**

9 (a) IN GENERAL.—In the case that the Children’s
10 Hospital GME Support Reauthorization Act of 2013 is en-
11 acted into law, the Comptroller General of the United
12 States shall, not later than November 30, 2017, conduct
13 an independent evaluation, and submit to the appropriate
14 committees of Congress a report, concerning the imple-
15 mentation of section 340E(h) of the Public Health Service
16 Act, as added by section 3 of the Children’s Hospital GME
17 Support Reauthorization Act of 2013.

18 (b) CONTENT.—The report described in subsection
19 (a) shall review and assess each of the following, with re-
20 spect to hospitals receiving payments under such section
21 340E(h) during the period of fiscal years 2015 through
22 2017:

23 (1) The number and type of such hospitals that
24 applied for such payments.

1 (2) The number and type of such hospitals re-
2 ceiving such payments.

3 (3) The amount of such payments awarded to
4 such hospitals.

5 (4) How such hospitals used such payments.

6 (5) The impact of such payments on—

7 (A) the number of pediatric providers; and

8 (B) health care needs of children.

9 **SEC. 215. SKILLED NURSING FACILITY VALUE-BASED PUR-**
10 **CHASING.**

11 (a) IN GENERAL.—Section 1888 of the Social Secu-
12 rity Act (42 U.S.C. 1395yy) is amended by adding at the
13 end the following new subsection:

14 “(g) SKILLED NURSING FACILITY READMISSION
15 MEASURE.—

16 “(1) READMISSION MEASURE.—Not later than
17 October 1, 2015, the Secretary shall specify a skilled
18 nursing facility all-cause all-condition hospital read-
19 mission measure (or any successor to such a meas-
20 ure).

21 “(2) RESOURCE USE MEASURE.—Not later than
22 October 1, 2016, the Secretary shall specify a meas-
23 ure to reflect an all-condition risk-adjusted poten-
24 tially preventable hospital readmission rate for
25 skilled nursing facilities.

1 “(3) MEASURE ADJUSTMENTS.—When speci-
 2 fying the measures under paragraphs (1) and (2),
 3 the Secretary shall devise a methodology to achieve
 4 a high level of reliability and validity, especially for
 5 skilled nursing facilities with a low volume of re-
 6 admissions.

7 “(4) PRE-RULEMAKING PROCESS (MEASURE AP-
 8 PLICATION PARTNERSHIP PROCESS).—The applica-
 9 tion of the provisions of section 1890A shall be op-
 10 tional in the case of a measure specified under para-
 11 graph (1) and a measure specified under paragraph
 12 (2).

13 “(5) FEEDBACK REPORTS TO SKILLED NURS-
 14 ING FACILITIES.—Beginning October 1, 2016, and
 15 every quarter thereafter, the Secretary shall provide
 16 confidential feedback reports to skilled nursing fa-
 17 cilities on the performance of such facilities with re-
 18 spect to a measure specified under paragraph (1) or
 19 (2).

20 “(6) PUBLIC REPORTING OF SKILLED NURSING
 21 FACILITIES.—

22 “(A) IN GENERAL.—Subject to subpara-
 23 graphs (B) and (C), the Secretary shall estab-
 24 lish procedures for making available to the pub-
 25 lic by posting on the Nursing Home Compare

1 Medicare website (or a successor website) de-
2 scribed in section 1819(i) information on the
3 performance of skilled nursing facilities with re-
4 spect to a measure specified under paragraph
5 (1) and a measure specified under paragraph
6 (2).

7 “(B) OPPORTUNITY TO REVIEW.—The pro-
8 cedures under subparagraph (A) shall ensure
9 that a skilled nursing facility has the oppor-
10 tunity to review and submit corrections to the
11 information that is to be made public with re-
12 spect to the facility prior to such information
13 being made public.

14 “(C) TIMING.—Such procedures shall pro-
15 vide that the information described in subpara-
16 graph (A) is made publicly available beginning
17 not later than October 1, 2017.

18 “(7) NON-APPLICATION OF PAPERWORK REDUC-
19 TION ACT.—Chapter 35 of title 44, United States
20 Code (commonly referred to as the ‘Paperwork Re-
21 duction Act of 1995’) shall not apply to this sub-
22 section.”.

23 (b) VALUE-BASED PURCHASING PROGRAM FOR
24 SKILLED NURSING FACILITIES.—Section 1888 of the So-
25 cial Security Act (42 U.S.C. 1395yy), as amended by sub-

1 section (a), is further amended by adding at the end the
2 following new subsection:

3 “(h) SKILLED NURSING FACILITY VALUE-BASED
4 PURCHASING PROGRAM.—

5 “(1) ESTABLISHMENT.—

6 “(A) IN GENERAL.—Subject to the suc-
7 ceeding provisions of this subsection, the Sec-
8 retary shall establish a skilled nursing facility
9 value-based purchasing program (in this sub-
10 section referred to as the ‘SNF VBP Program’)
11 under which value-based incentive payments are
12 made in a fiscal year to skilled nursing facili-
13 ties.

14 “(B) PROGRAM TO BEGIN IN FISCAL YEAR
15 2019.—The SNF VBP Program shall apply to
16 payments for services furnished on or after Oc-
17 tober 1, 2018.

18 “(2) APPLICATION OF MEASURES.—

19 “(A) IN GENERAL.—The Secretary shall
20 apply the measure specified under subsection
21 (g)(1) for purposes of the SNF VBP Program.

22 “(B) REPLACEMENT.—For purposes of the
23 SNF VBP Program, the Secretary shall apply
24 the measure specified under (g)(2) instead of

1 the measure specified under (g)(1) as soon as
2 practicable.

3 “(3) PERFORMANCE STANDARDS.—

4 “(A) ESTABLISHMENT.—The Secretary
5 shall establish performance standards with re-
6 spect to the measure applied under paragraph
7 (2) for a performance period for a fiscal year.

8 “(B) HIGHER OF ACHIEVEMENT AND IM-
9 PROVEMENT.—The performance standards es-
10 tablished under subparagraph (A) shall include
11 levels of achievement and improvement. In cal-
12 culating the SNF performance score under
13 paragraph (4), the Secretary shall use the high-
14 er of either improvement or achievement.

15 “(C) TIMING.—The Secretary shall estab-
16 lish and announce the performance standards
17 established under subparagraph (A) not later
18 than 60 days prior to the beginning of the per-
19 formance period for the fiscal year involved.

20 “(4) SNF PERFORMANCE SCORE.—

21 “(A) IN GENERAL.—The Secretary shall
22 develop a methodology for assessing the total
23 performance of each skilled nursing facility
24 based on performance standards established
25 under paragraph (3) with respect to the meas-

ure applied under paragraph (2). Using such methodology, the Secretary shall provide for an assessment (in this subsection referred to as the ‘SNF performance score’) for each skilled nursing facility for each such performance period.

“(B) RANKING OF SNF PERFORMANCE SCORES.—The Secretary shall, for the performance period for each fiscal year, rank the SNF performance scores determined under subparagraph (A) from low to high.

“(5) CALCULATION OF VALUE-BASED INCENTIVE PAYMENTS.—

“(A) IN GENERAL.—With respect to a skilled nursing facility, based on the ranking under paragraph (4)(B) for a performance period for a fiscal year, the Secretary shall increase the adjusted Federal per diem rate determined under subsection (e)(4)(G) otherwise applicable to such skilled nursing facility (and after application of paragraph (6)) for services furnished by such facility during such fiscal year by the value-based incentive payment amount under subparagraph (B).

“(B) VALUE-BASED INCENTIVE PAYMENT AMOUNT.—The value-based incentive payment

1 amount for services furnished by a skilled nurs-
2 ing facility in a fiscal year shall be equal to the
3 product of—

4 “(i) the adjusted Federal per diem
5 rate determined under subsection (e)(4)(G)
6 otherwise applicable to such skilled nursing
7 facility for such services furnished by the
8 skilled nursing facility during such fiscal
9 year; and

10 “(ii) the value-based incentive pay-
11 ment percentage specified under subpara-
12 graph (C) for the skilled nursing facility
13 for such fiscal year.

14 “(C) VALUE-BASED INCENTIVE PAYMENT
15 PERCENTAGE.—

16 “(i) IN GENERAL.—The Secretary
17 shall specify a value-based incentive pay-
18 ment percentage for a skilled nursing facil-
19 ity for a fiscal year which may include a
20 zero percentage.

21 “(ii) REQUIREMENTS.—In specifying
22 the value-based incentive payment percent-
23 age for each skilled nursing facility for a
24 fiscal year under clause (i), the Secretary
25 shall ensure that—

1 “(I) such percentage is based on
2 the SNF performance score of the
3 skilled nursing facility provided under
4 paragraph (4) for the performance pe-
5 riod for such fiscal year;

6 “(II) the application of all such
7 percentages in such fiscal year results
8 in an appropriate distribution of
9 value-based incentive payments under
10 subparagraph (B) such that—

11 “(aa) skilled nursing facili-
12 ties with the highest rankings
13 under paragraph (4)(B) receive
14 the highest value-based incentive
15 payment amounts under subpara-
16 graph (B);

17 “(bb) skilled nursing facili-
18 ties with the lowest rankings
19 under paragraph (4)(B) receive
20 the lowest value-based incentive
21 payment amounts under subpara-
22 graph (B); and

23 “(cc) in the case of skilled
24 nursing facilities in the lowest 40
25 percent of the ranking under

1 paragraph (4)(B), the payment
2 rate under subparagraph (A) for
3 services furnished by such facility
4 during such fiscal year shall be
5 less than the payment rate for
6 such services for such fiscal year
7 that would otherwise apply under
8 subsection (e)(4)(G) without ap-
9 plication of this subsection; and

10 “(III) the total amount of value-
11 based incentive payments under this
12 paragraph for all skilled nursing fa-
13 cilities in such fiscal year shall be
14 greater than or equal to 50 percent,
15 but not greater than 70 percent, of
16 the total amount of the reductions to
17 payments for such fiscal year under
18 paragraph (6), as estimated by the
19 Secretary.

20 “(6) FUNDING FOR VALUE-BASED INCENTIVE
21 PAYMENTS.—

22 “(A) IN GENERAL.—The Secretary shall
23 reduce the adjusted Federal per diem rate de-
24 termined under subsection (e)(4)(G) otherwise
25 applicable to a skilled nursing facility for serv-

1 ices furnished by such facility during a fiscal
2 year (beginning with fiscal year 2019) by the
3 applicable percent (as defined in subparagraph
4 (B)). The Secretary shall make such reductions
5 for all skilled nursing facilities in the fiscal year
6 involved, regardless of whether or not the
7 skilled nursing facility has been determined by
8 the Secretary to have earned a value-based in-
9 centive payment under paragraph (5) for such
10 fiscal year.

11 “(B) APPLICABLE PERCENT.—For pur-
12 poses of subparagraph (A), the term ‘applicable
13 percent’ means, with respect to fiscal year 2019
14 and succeeding fiscal years, 2 percent.

15 “(7) ANNOUNCEMENT OF NET RESULT OF AD-
16 JUSTMENTS.—Under the SNF VBP Program, the
17 Secretary shall, not later than 60 days prior to the
18 fiscal year involved, inform each skilled nursing fa-
19 cility of the adjustments to payments to the skilled
20 nursing facility for services furnished by such facility
21 during the fiscal year under paragraphs (5) and (6).

22 “(8) NO EFFECT IN SUBSEQUENT FISCAL
23 YEARS.—The value-based incentive payment under
24 paragraph (5) and the payment reduction under
25 paragraph (6) shall each apply only with respect to

1 the fiscal year involved, and the Secretary shall not
2 take into account such value-based incentive pay-
3 ment or payment reduction in making payments to
4 a skilled nursing facility under this section in a sub-
5 sequent fiscal year.

6 “(9) PUBLIC REPORTING.—

7 “(A) SNF SPECIFIC INFORMATION.—The
8 Secretary shall make available to the public, by
9 posting on the Nursing Home Compare Medi-
10 care website (or a successor website) described
11 in section 1819(i) in an easily understandable
12 format, information regarding the performance
13 of individual skilled nursing facilities under the
14 SNF VBP Program, with respect to a fiscal
15 year, including—

16 “(i) the SNF performance score of the
17 skilled nursing facility for such fiscal year;
18 and

19 “(ii) the ranking of the skilled nursing
20 facility under paragraph (4)(B) for the
21 performance period for such fiscal year.

22 “(B) AGGREGATE INFORMATION.—The
23 Secretary shall periodically post on the Nursing
24 Home Compare Medicare website (or a suc-
25 cessor website) described in section 1819(i) ag-

gregate information on the SNF VBP Program,
including—

“(i) the range of SNF performance
scores provided under paragraph (4)(A);
and

“(ii) the number of skilled nursing fa-
cilities receiving value-based incentive pay-
ments under paragraph (5) and the range
and total amount of such value-based in-
centive payments.

“(10) LIMITATION ON REVIEW.—There shall be
no administrative or judicial review under section
1869, section 1878, or otherwise of the following:

“(A) The methodology used to determine
the value-based incentive payment percentage
and the amount of the value-based incentive
payment under paragraph (5).

“(B) The determination of the amount of
funding available for such value-based incentive
payments under paragraph (5)(C)(ii)(III) and
the payment reduction under paragraph (6).

“(C) The establishment of the performance
standards under paragraph (3) and the per-
formance period.

1 “(D) The methodology developed under
2 paragraph (4) that is used to calculate SNF
3 performance scores and the calculation of such
4 scores.

5 “(E) The ranking determinations under
6 paragraph (4)(B).

7 “(11) FUNDING FOR PROGRAM MANAGE-
8 MENT.—The Secretary shall provide for the one time
9 transfer from the Federal Hospital Insurance Trust
10 Fund established under section 1817 to the Centers
11 for Medicare & Medicaid Services Program Manage-
12 ment Account of—

13 “(A) for purposes of subsection (g)(2),
14 \$2,000,000; and

15 “(B) for purposes of implementing this
16 subsection, \$10,000,000.

17 Such funds shall remain available until expended.”.

18 (c) MEDPAC STUDY.—Not later than June 30,
19 2021, the Medicare Payment Advisory Commission shall
20 submit to Congress a report that reviews the progress of
21 the skilled nursing facility value-based purchasing pro-
22 gram established under section 1888(h) of the Social Se-
23 curity Act, as added by subsection (b), and makes rec-
24 ommendations, as appropriate, on any improvements that
25 should be made to such program. For purposes of the pre-

vious sentence, the Medicare Payment Advisory Commission shall consider any unintended consequences with respect to such skilled nursing facility value-based purchasing program and any potential adjustments to the readmission measure specified under section 1888(g)(1) of such Act, as added by subsection (a), for purposes of determining the effect of the socio-economic status of a beneficiary under the Medicare program under title XVIII of the Social Security Act for the SNF performance score of a skilled nursing facility provided under section 1888(h)(4) of such Act, as added by subsection (b).

SEC. 216. IMPROVING MEDICARE POLICIES FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended by inserting after section 1834 (42 U.S.C. 1395m) the following new section:

“SEC. 1834A. IMPROVING POLICIES FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

“(a) REPORTING OF PRIVATE SECTOR PAYMENT RATES FOR ESTABLISHMENT OF MEDICARE PAYMENT RATES.—

“(1) IN GENERAL.—Beginning January 1, 2016, and every 3 years thereafter (or, annually, in the case of reporting with respect to an advanced diagnostic laboratory test, as defined in subsection

(d)(5)), an applicable laboratory (as defined in paragraph (2)) shall report to the Secretary, at a time specified by the Secretary, applicable information (as defined in paragraph (3)) for a data collection period (as defined in paragraph (4)) for each clinical diagnostic laboratory test that the laboratory furnishes during such period for which payment is made under this part.

“(2) DEFINITION OF APPLICABLE LABORATORY.—In this section, the term ‘applicable laboratory’ means a laboratory that, with respect to its revenues under this title, a majority of such revenues are from this section, section 1833(h), or section 1848. The Secretary may establish a low volume or low expenditure threshold for excluding a laboratory from the definition of applicable laboratory under this paragraph, as the Secretary determines appropriate.

“(3) APPLICABLE INFORMATION DEFINED.—

“(A) IN GENERAL.—In this section, subject to subparagraph (B), the term ‘applicable information’ means, with respect to a laboratory test for a data collection period, the following:

1 “(i) The payment rate (as determined
2 in accordance with paragraph (5)) that
3 was paid by each private payor for the test
4 during the period.

5 “(ii) The volume of such tests for
6 each such payor for the period.

7 “(B) EXCEPTION FOR CERTAIN CONTRAC-
8 TUAL ARRANGEMENTS.—Such term shall not
9 include information with respect to a laboratory
10 test for which payment is made on a capitated
11 basis or other similar payment basis during the
12 data collection period.

13 “(4) DATA COLLECTION PERIOD DEFINED.—In
14 this section, the term ‘data collection period’ means
15 a period of time, such as a previous 12 month pe-
16 riod, specified by the Secretary.

17 “(5) TREATMENT OF DISCOUNTS.—The pay-
18 ment rate reported by a laboratory under this sub-
19 section shall reflect all discounts, rebates, coupons,
20 and other price concessions, including those de-
21 scribed in section 1847A(c)(3).

22 “(6) ENSURING COMPLETE REPORTING.—In
23 the case where an applicable laboratory has more
24 than one payment rate for the same payor for the
25 same test or more than one payment rate for dif-

1 ferent payors for the same test, the applicable lab-
2 oratory shall report each such payment rate and the
3 volume for the test at each such rate under this sub-
4 section. Beginning with January 1, 2019, the Sec-
5 retary may establish rules to aggregate reporting
6 with respect to the situations described in the pre-
7 ceding sentence.

8 “(7) CERTIFICATION.—An officer of the labora-
9 tory shall certify the accuracy and completeness of
10 the information reported under this subsection.

11 “(8) PRIVATE PAYOR DEFINED.—In this sec-
12 tion, the term ‘private payor’ means the following:

13 “(A) A health insurance issuer and a
14 group health plan (as such terms are defined in
15 section 2791 of the Public Health Service Act).

16 “(B) A Medicare Advantage plan under
17 part C.

18 “(C) A medicaid managed care organiza-
19 tion (as defined in section 1903(m)).

20 “(9) CIVIL MONEY PENALTY.—

21 “(A) IN GENERAL.—If the Secretary deter-
22 mines that an applicable laboratory has failed
23 to report or made a misrepresentation or omis-
24 sion in reporting information under this sub-
25 section with respect to a clinical diagnostic lab-

1 oratory test, the Secretary may apply a civil
2 money penalty in an amount of up to \$10,000
3 per day for each failure to report or each such
4 misrepresentation or omission.

5 “(B) APPLICATION.—The provisions of
6 section 1128A (other than subsections (a) and
7 (b)) shall apply to a civil money penalty under
8 this paragraph in the same manner as they
9 apply to a civil money penalty or proceeding
10 under section 1128A(a).

11 “(10) CONFIDENTIALITY OF INFORMATION.—
12 Notwithstanding any other provision of law, infor-
13 mation disclosed by a laboratory under this sub-
14 section is confidential and shall not be disclosed by
15 the Secretary or a Medicare contractor in a form
16 that discloses the identity of a specific payor or lab-
17 oratory, or prices charged or payments made to any
18 such laboratory, except—

19 “(A) as the Secretary determines to be
20 necessary to carry out this section;

21 “(B) to permit the Comptroller General to
22 review the information provided;

23 “(C) to permit the Director of the Con-
24 gressional Budget Office to review the informa-
25 tion provided; and

1 “(D) to permit the Medicare Payment Ad-
2 visory Commission to review the information
3 provided.

4 “(11) PROTECTION FROM PUBLIC DISCLO-
5 SURE.—A payor shall not be identified on informa-
6 tion reported under this subsection. The name of an
7 applicable laboratory under this subsection shall be
8 exempt from disclosure under section 552(b)(3) of
9 title 5, United States Code.

10 “(12) REGULATIONS.—Not later than June 30,
11 2015, the Secretary shall establish through notice
12 and comment rulemaking parameters for data collec-
13 tion under this subsection.

14 “(b) PAYMENT FOR CLINICAL DIAGNOSTIC LABORA-
15 TORY TESTS.—

16 “(1) USE OF PRIVATE PAYOR RATE INFORMA-
17 TION TO DETERMINE MEDICARE PAYMENT RATES.—

18 “(A) IN GENERAL.—Subject to paragraph
19 (3) and subsections (c) and (d), in the case of
20 a clinical diagnostic laboratory test furnished on
21 or after January 1, 2017, the payment amount
22 under this section shall be equal to the weighted
23 median determined for the test under para-
24 graph (2) for the most recent data collection
25 period.

1 “(B) APPLICATION OF PAYMENT AMOUNTS
2 TO HOSPITAL LABORATORIES.—The payment
3 amounts established under this section shall
4 apply to a clinical diagnostic laboratory test
5 furnished by a hospital laboratory if such test
6 is paid for separately, and not as part of a bun-
7 dled payment under section 1833(t).

8 “(2) CALCULATION OF WEIGHTED MEDIAN.—
9 For each laboratory test with respect to which infor-
10 mation is reported under subsection (a) for a data
11 collection period, the Secretary shall calculate a
12 weighted median for the test for the period, by
13 arraying the distribution of all payment rates re-
14 ported for the period for each test weighted by vol-
15 ume for each payor and each laboratory.

16 “(3) PHASE-IN OF REDUCTIONS FROM PRIVATE
17 PAYOR RATE IMPLEMENTATION.—

18 “(A) IN GENERAL.—Payment amounts de-
19 termined under this subsection for a clinical di-
20 agnostic laboratory test for each of 2017
21 through 2022 shall not result in a reduction in
22 payments for a clinical diagnostic laboratory
23 test for the year of greater than the applicable
24 percent (as defined in subparagraph (B)) of the

1 amount of payment for the test for the pre-
2 ceding year.

3 “(B) APPLICABLE PERCENT DEFINED.—In
4 this paragraph, the term ‘applicable percent’
5 means—

6 “(i) for each of 2017 through 2019,
7 10 percent; and

8 “(ii) for each of 2020 through 2022,
9 15 percent.

10 “(C) NO APPLICATION TO NEW TESTS.—
11 This paragraph shall not apply to payment
12 amounts determined under this section for ei-
13 ther of the following.

14 “(i) A new test under subsection (c).

15 “(ii) A new advanced diagnostic test
16 (as defined in subsection (d)(5)) under
17 subsection (d).

18 “(4) APPLICATION OF MARKET RATES.—

19 “(A) IN GENERAL.—Subject to paragraph
20 (3), once established for a year following a data
21 collection period, the payment amounts under
22 this subsection shall continue to apply until the
23 year following the next data collection period.

24 “(B) OTHER ADJUSTMENTS NOT APPLICA-
25 BLE.—The payment amounts under this section

1 shall not be subject to any adjustment (includ-
 2 ing any geographic adjustment, budget neu-
 3 trality adjustment, annual update, or other ad-
 4 justment).

5 “(5) SAMPLE COLLECTION FEE.—In the case of
 6 a sample collected from an individual in a skilled
 7 nursing facility or by a laboratory on behalf of a
 8 home health agency, the nominal fee that would oth-
 9 erwise apply under section 1833(h)(3)(A) shall be
 10 increased by \$2.

11 “(c) PAYMENT FOR NEW TESTS THAT ARE NOT AD-
 12 VANCED DIAGNOSTIC LABORATORY TESTS.—

13 “(1) PAYMENT DURING INITIAL PERIOD.—In
 14 the case of a clinical diagnostic laboratory test that
 15 is assigned a new or substantially revised HCPCS
 16 code on or after the date of enactment of this sec-
 17 tion, and which is not an advanced diagnostic lab-
 18 oratory test (as defined in subsection (d)(5)), during
 19 an initial period until payment rates under sub-
 20 section (b) are established for the test, payment for
 21 the test shall be determined—

22 “(A) using cross-walking (as described in
 23 section 414.508(a) of title 42, Code of Federal
 24 Regulations, or any successor regulation) to the
 25 most appropriate existing test under the fee

1 schedule under this section during that period;
2 or

3 “(B) if no existing test is comparable to
4 the new test, according to the gapfilling process
5 described in paragraph (2).

6 “(2) GAPFILLING PROCESS DESCRIBED.—The
7 gapfilling process described in this paragraph shall
8 take into account the following sources of informa-
9 tion to determine gapfill amounts, if available:

10 “(A) Charges for the test and routine dis-
11 counts to charges.

12 “(B) Resources required to perform the
13 test.

14 “(C) Payment amounts determined by
15 other payors.

16 “(D) Charges, payment amounts, and re-
17 sources required for other tests that may be
18 comparable or otherwise relevant.

19 “(E) Other criteria the Secretary deter-
20 mines appropriate.

21 “(3) ADDITIONAL CONSIDERATION.—In deter-
22 mining the payment amount under crosswalking or
23 gapfilling processes under this subsection, the Sec-
24 retary shall consider recommendations from the
25 panel established under subsection (f)(1).

1 “(4) EXPLANATION OF PAYMENT RATES.—In
2 the case of a clinical diagnostic laboratory test for
3 which payment is made under this subsection, the
4 Secretary shall make available to the public an ex-
5 planation of the payment rate for the test, including
6 an explanation of how the criteria described in para-
7 graph (2) and paragraph (3) are applied.

8 “(d) PAYMENT FOR NEW ADVANCED DIAGNOSTIC
9 LABORATORY TESTS.—

10 “(1) PAYMENT DURING INITIAL PERIOD.—

11 “(A) IN GENERAL.—In the case of an ad-
12 vanced diagnostic laboratory test for which pay-
13 ment has not been made under the fee schedule
14 under section 1833(h) prior to the date of en-
15 actment of this section, during an initial period
16 of three quarters, the payment amount for the
17 test for such period shall be based on the actual
18 list charge for the laboratory test.

19 “(B) ACTUAL LIST CHARGE.—For pur-
20 poses of subparagraph (A), the term ‘actual list
21 charge’, with respect to a laboratory test fur-
22 nished during such period, means the publicly
23 available rate on the first day at which the test
24 is available for purchase by a private payor.

1 “(2) SPECIAL RULE FOR TIMING OF INITIAL
2 REPORTING.—With respect to an advanced diag-
3 nostic laboratory test described in paragraph (1)(A),
4 an applicable laboratory shall initially be required to
5 report under subsection (a) not later than the last
6 day of the second quarter of the initial period under
7 such paragraph.

8 “(3) APPLICATION OF MARKET RATES AFTER
9 INITIAL PERIOD.—Subject to paragraph (4), data re-
10 ported under paragraph (2) shall be used to estab-
11 lish the payment amount for an advanced diagnostic
12 laboratory test after the initial period under para-
13 graph (1)(A) using the methodology described in
14 subsection (b). Such payment amount shall continue
15 to apply until the year following the next data collec-
16 tion period.

17 “(4) RECOUPMENT IF ACTUAL LIST CHARGE
18 EXCEEDS MARKET RATE.—With respect to the initial
19 period described in paragraph (1)(A), if, after such
20 period, the Secretary determines that the payment
21 amount for an advanced diagnostic laboratory test
22 under paragraph (1)(A) that was applicable during
23 the period was greater than 130 percent of the pay-
24 ment amount for the test established using the
25 methodology described in subsection (b) that is ap-

1 plicable after such period, the Secretary shall recoup
2 the difference between such payment amounts for
3 tests furnished during such period.

4 “(5) ADVANCED DIAGNOSTIC LABORATORY
5 TEST DEFINED.—In this subsection, the term ‘ad-
6 vanced diagnostic laboratory test’ means a clinical
7 diagnostic laboratory test covered under this part
8 that is offered and furnished only by a single labora-
9 tory and not sold for use by a laboratory other than
10 the original developing laboratory (or a successor
11 owner) and meets one of the following criteria:

12 “(A) The test is an analysis of multiple
13 biomarkers of DNA, RNA, or proteins com-
14 bined with a unique algorithm to yield a single
15 patient-specific result.

16 “(B) The test is cleared or approved by the
17 Food and Drug Administration.

18 “(C) The test meets other similar criteria
19 established by the Secretary.

20 “(e) CODING.—

21 “(1) TEMPORARY CODES FOR CERTAIN NEW
22 TESTS.—

23 “(A) IN GENERAL.—The Secretary shall
24 adopt temporary HCPCS codes to identify new
25 advanced diagnostic laboratory tests (as defined

1 in subsection (d)(5)) and new laboratory tests
2 that are cleared or approved by the Food and
3 Drug Administration.

4 “(B) DURATION.—

5 “(i) IN GENERAL.—Subject to clause
6 (ii), the temporary code shall be effective
7 until a permanent HCPCS code is estab-
8 lished (but not to exceed 2 years).

9 “(ii) EXCEPTION.—The Secretary
10 may extend the temporary code or estab-
11 lish a permanent HCPCS code, as the Sec-
12 retary determines appropriate.

13 “(2) EXISTING TESTS.—Not later than January
14 1, 2016, for each existing advanced diagnostic lab-
15 oratory test (as so defined) and each existing clinical
16 diagnostic laboratory test that is cleared or approved
17 by the Food and Drug Administration for which
18 payment is made under this part as of the date of
19 enactment of this section, if such test has not al-
20 ready been assigned a unique HCPCS code, the Sec-
21 retary shall—

22 “(A) assign a unique HCPCS code for the
23 test; and

24 “(B) publicly report the payment rate for
25 the test.

1 “(3) ESTABLISHMENT OF UNIQUE IDENTIFIER
2 FOR CERTAIN TESTS.—For purposes of tracking and
3 monitoring, if a laboratory or a manufacturer re-
4 quests a unique identifier for an advanced diagnostic
5 laboratory test (as so defined) or a laboratory test
6 that is cleared or approved by the Food and Drug
7 Administration, the Secretary shall utilize a means
8 to uniquely track such test through a mechanism
9 such as a HCPCS code or modifier.

10 “(f) INPUT FROM CLINICIANS AND TECHNICAL EX-
11 PERTS.—

12 “(1) IN GENERAL.—The Secretary shall consult
13 with an expert outside advisory panel, established by
14 the Secretary not later than July 1, 2015, composed
15 of an appropriate selection of individuals with exper-
16 tise, which may include molecular pathologists, re-
17 searchers, and individuals with expertise in labora-
18 tory science or health economics, in issues related to
19 clinical diagnostic laboratory tests, which may in-
20 clude the development, validation, performance, and
21 application of such tests, to provide—

22 “(A) input on—

23 “(i) the establishment of payment
24 rates under this section for new clinical di-
25 agnostic laboratory tests, including wheth-

1 er to use crosswalking or gapfilling proc-
2 esses to determine payment for a specific
3 new test; and

4 “(ii) the factors used in determining
5 coverage and payment processes for new
6 clinical diagnostic laboratory tests; and

7 “(B) recommendations to the Secretary
8 under this section.

9 “(2) COMPLIANCE WITH FACA.—The panel
10 shall be subject to the Federal Advisory Committee
11 Act (5 U.S.C. App.).

12 “(3) CONTINUATION OF ANNUAL MEETING.—
13 The Secretary shall continue to convene the annual
14 meeting described in section 1833(h)(8)(B)(iii) after
15 the implementation of this section for purposes of
16 receiving comments and recommendations (and data
17 on which the recommendations are based) as de-
18 scribed in such section on the establishment of pay-
19 ment amounts under this section.

20 “(g) COVERAGE.—

21 “(1) ISSUANCE OF COVERAGE POLICIES.—

22 “(A) IN GENERAL.—A medicare adminis-
23 trative contractor shall only issue a coverage
24 policy with respect to a clinical diagnostic lab-
25 oratory test in accordance with the process for

1 making a local coverage determination (as de-
2 fined in section 1869(f)(2)(B)), including the
3 appeals and review process for local coverage
4 determinations under part 426 of title 42, Code
5 of Federal Regulations (or successor regula-
6 tions).

7 “(B) NO EFFECT ON NATIONAL COVERAGE
8 DETERMINATION PROCESS.—This paragraph
9 shall not apply to the national coverage deter-
10 mination process (as defined in section
11 1869(f)(1)(B)).

12 “(C) EFFECTIVE DATE.—This paragraph
13 shall apply to coverage policies issued on or
14 after January 1, 2015.

15 “(2) DESIGNATION OF ONE OR MORE MEDICARE
16 ADMINISTRATIVE CONTRACTORS FOR CLINICAL DIAG-
17 NOSTIC LABORATORY TESTS.—The Secretary may
18 designate one or more (not to exceed 4) medicare
19 administrative contractors to either establish cov-
20 erage policies or establish coverage policies and proc-
21 ess claims for payment for clinical diagnostic labora-
22 tory tests, as determined appropriate by the Sec-
23 retary.

24 “(h) IMPLEMENTATION.—

1 “(1) IMPLEMENTATION.—There shall be no ad-
2 ministrative or judicial review under section 1869,
3 section 1878, or otherwise, of the establishment of
4 payment amounts under this section.

5 “(2) ADMINISTRATION.—Chapter 35 of title 44,
6 United States Code, shall not apply to information
7 collected under this section.

8 “(3) FUNDING.—For purposes of implementing
9 this section, the Secretary shall provide for the
10 transfer, from the Federal Supplementary Medical
11 Insurance Trust Fund under section 1841, to the
12 Centers for Medicare & Medicaid Services Program
13 Management Account, for each of fiscal years 2014
14 through 2018, \$4,000,000, and for each of fiscal
15 years 2019 through 2023, \$3,000,000. Amounts
16 transferred under the preceding sentence shall re-
17 main available until expended.

18 “(i) TRANSITIONAL RULE.—During the period begin-
19 ning on the date of enactment of this section and ending
20 on December 31, 2016, with respect to advanced diag-
21 nostic laboratory tests under this part, the Secretary shall
22 use the methodologies for pricing, coding, and coverage
23 in effect on the day before such date of enactment, which
24 may include cross-walking or gapfilling methods.”.

25 (b) CONFORMING AMENDMENTS.—

1 (1) Section 1833(a) of the Social Security Act
2 (42 U.S.C. 1395l(a)) is amended—

3 (A) in paragraph (1)(D)—

4 (i) by striking “(i) on the basis” and
5 inserting “(i)(I) on the basis”;

6 (ii) in subclause (I), as added by
7 clause (i), by striking “subsection (h)(1)”
8 and inserting “subsection (h)(1) (for tests
9 furnished before January 1, 2017)”;

10 (iii) by striking “or (ii)” and inserting
11 “or (II) under section 1834A (for tests
12 furnished on or after January 1, 2017),
13 the amount paid shall be equal to 80 per-
14 cent (or 100 percent, in the case of such
15 tests for which payment is made on an as-
16 signment-related basis) of the lesser of the
17 amount determined under such section or
18 the amount of the charges billed for the
19 tests, or (ii)”;

20 (iv) in clause (ii), by striking “on the
21 basis” and inserting “for tests furnished
22 before January 1, 2017, on the basis”;

23 (B) in paragraph (2)(D)—

24 (i) by striking “(i) on the basis” and
25 inserting “(i)(I) on the basis”;

1 (ii) in subclause (I), as added by
2 clause (i), by striking “subsection (h)(1)”
3 and inserting “subsection (h)(1) (for tests
4 furnished before January 1, 2017)”;

5 (iii) by striking “or (ii)” and inserting
6 “or (II) under section 1834A (for tests
7 furnished on or after January 1, 2017),
8 the amount paid shall be equal to 80 per-
9 cent (or 100 percent, in the case of such
10 tests for which payment is made on an as-
11 signment-related basis or to a provider
12 having an agreement under section 1866)
13 of the lesser of the amount determined
14 under such section or the amount of the
15 charges billed for the tests, or (ii)”;

16 (iv) in clause (ii), by striking “on the
17 basis” and inserting “for tests furnished
18 before January 1, 2017, on the basis”;

19 (C) in subsection (b)(3)(B), by striking
20 “on the basis” and inserting “for tests fur-
21 nished before January 1, 2017, on the basis”;

22 (D) in subsection (h)(2)(A)(i), by striking
23 “and subject to” and inserting “and, for tests
24 furnished before the date of enactment of sec-
25 tion 1834A, subject to”;

1 (E) in subsection (h)(3), in the matter pre-
 2 ceding subparagraph (A), by striking “fee
 3 schedules” and inserting “fee schedules (for
 4 tests furnished before January 1, 2017) or
 5 under section 1834A (for tests furnished on or
 6 after January 1, 2017), subject to subsection
 7 (b)(5) of such section”;

8 (F) in subsection (h)(6), by striking “In
 9 the case” and inserting “For tests furnished be-
 10 fore January 1, 2017, in the case”; and

11 (G) in subsection (h)(7), in the first sen-
 12 tence—

13 (i) by striking “and (4)” and inserting
 14 “and (4) and section 1834A”; and

15 (ii) by striking “under this sub-
 16 section” and inserting “under this part”.

17 (2) Section 1869(f)(2) of the Social Security
 18 Act (42 U.S.C. 1395ff(f)(2)) is amended by adding
 19 at the end the following new subparagraph:

20 “(C) LOCAL COVERAGE DETERMINATIONS
 21 FOR CLINICAL DIAGNOSTIC LABORATORY
 22 TESTS.—For provisions relating to local cov-
 23 erage determinations for clinical diagnostic lab-
 24 oratory tests, see section 1834A(g).”.

1 (c) GAO STUDY AND REPORT; MONITORING OF
2 MEDICARE EXPENDITURES AND IMPLEMENTATION OF
3 NEW PAYMENT SYSTEM FOR LABORATORY TESTS.—

4 (1) GAO STUDY AND REPORT ON IMPLEMENTA-
5 TION OF NEW PAYMENT RATES FOR CLINICAL DIAG-
6 NOSTIC LABORATORY TESTS.—

7 (A) STUDY.—The Comptroller General of
8 the United States (in this subsection referred to
9 as the “Comptroller General”) shall conduct a
10 study on the implementation of section 1834A
11 of the Social Security Act, as added by sub-
12 section (a). The study shall include an analysis
13 of—

14 (i) payment rates paid by private
15 payors for laboratory tests furnished in
16 various settings, including—

17 (I) how such payment rates com-
18 pare across settings;

19 (II) the trend in payment rates
20 over time; and

21 (III) trends by private payors to
22 move to alternative payment meth-
23 odologies for laboratory tests;

1 (ii) the conversion to the new payment
2 rate for laboratory tests under such sec-
3 tion;

4 (iii) the impact of such implementa-
5 tion on beneficiary access under title
6 XVIII of the Social Security Act;

7 (iv) the impact of the new payment
8 system on laboratories that furnish a low
9 volume of services and laboratories that
10 specialize in a small number of tests;

11 (v) the number of new Healthcare
12 Common Procedure Coding System
13 (HCPCS) codes issued for laboratory tests;

14 (vi) the spending trend for laboratory
15 tests under such title;

16 (vii) whether the information reported
17 by laboratories and the new payment rates
18 for laboratory tests under such section ac-
19 curately reflect market prices;

20 (viii) the initial list price for new lab-
21 oratory tests and the subsequent reported
22 rates for such tests under such section;

23 (ix) changes in the number of ad-
24 vanced diagnostic laboratory tests and lab-
25 oratory tests cleared or approved by the

1 Food and Drug Administration for which
2 payment is made under such section; and
3 (x) healthcare economic information
4 on downstream cost impacts for such tests
5 and decision making based on accepted
6 methodologies.

7 (B) REPORT.—Not later than October 1,
8 2018, the Comptroller General shall submit to
9 the Committee on Ways and Means and the
10 Committee on Energy and Commerce of the
11 House of Representatives and the Committee
12 on Finance of the Senate a report on the study
13 under subparagraph (A), including rec-
14 ommendations for such legislation and adminis-
15 trative action as the Comptroller General deter-
16 mines appropriate.

17 (2) MONITORING OF MEDICARE EXPENDITURES
18 AND IMPLEMENTATION OF NEW PAYMENT SYSTEM
19 FOR LABORATORY TESTS.—The Inspector General of
20 the Department of Health and Human Services
21 shall—

22 (A) publicly release an annual analysis of
23 the top 25 laboratory tests by expenditures
24 under title XVIII of the Social Security Act;
25 and

1 (B) conduct analyses the Inspector General
 2 determines appropriate with respect to the im-
 3 plementation and effect of the new payment
 4 system for laboratory tests under section 1834A
 5 of the Social Security Act, as added by sub-
 6 section (a).

7 **SEC. 217. REVISIONS UNDER THE MEDICARE ESRD PRO-**
 8 **SPECTIVE PAYMENT SYSTEM.**

9 (a) DELAY OF IMPLEMENTATION OF ORAL-ONLY
 10 POLICY.—Section 632(b)(1) of the American Taxpayer
 11 Relief Act of 2012 (42 U.S.C. 1395rr note) is amended—

12 (1) by striking “2016” and inserting “2024”;
 13 and

14 (2) by adding at the end the following new sen-
 15 tence: “Notwithstanding section 1881(b)(14)(A)(ii)
 16 of the Social Security Act (42 U.S.C.
 17 1395rr(b)(14)(A)(ii)), implementation of the policy
 18 described in the previous sentence shall be based on
 19 data from the most recent year available.”.

20 (b) MITIGATION OF THE APPLICATION OF ADJUST-
 21 MENT TO ESRD BUNDLED PAYMENT RATE TO ACCOUNT
 22 FOR CHANGES IN THE UTILIZATION OF CERTAIN DRUGS
 23 AND BIOLOGICALS.—

24 (1) IN GENERAL.—Section 1881(b)(14)(I) of
 25 the Social Security Act (42 U.S.C. 1395rr(b)(14)(I))

1 is amended by inserting “and before January 1,
2 2015,” after “January 1, 2014,”.

3 (2) MARKET BASKET.—Section
4 1881(b)(14)(F)(i) of the Social Security Act (42
5 U.S.C. 1395rr(b)(14)(F)(i)) is amended—

6 (A) in subclause (I)—

7 (i) by striking “subclause (II)” and
8 inserting “subclauses (II) and (III)”; and

9 (ii) by adding at the end the following
10 new sentence: “In order to accomplish the
11 purposes of subparagraph (I) with respect
12 to 2016, 2017, and 2018, after deter-
13 mining the increase factor described in the
14 preceding sentence for each of 2016, 2017,
15 and 2018, the Secretary shall reduce such
16 increase factor by 1.25 percentage points
17 for each of 2016 and 2017 and by 1 per-
18 centage point for 2018.”;

19 (B) in subclause (II), by striking “For
20 2012” and inserting “Subject to subclause
21 (III), for 2012”; and

22 (C) by adding at the end the following new
23 subclause:

24 “(III) Notwithstanding subclauses (I) and (II),
25 in order to accomplish the purposes of subparagraph

1 (I) with respect to 2015, the increase factor de-
2 scribed in subclause (I) for 2015 shall be 0.0 percent
3 pursuant to the regulation issued by the Secretary
4 on December 2, 2013, entitled ‘Medicare Program;
5 End-Stage Renal Disease Prospective Payment Sys-
6 tem, Quality Incentive Program, and Durable Med-
7 ical Equipment, Prosthetics, Orthotics, and Supplies;
8 Final Rule’ (78 Fed. Reg. 72156).”.

9 (c) DRUG DESIGNATIONS.—As part of the promulga-
10 tion of annual rule for the Medicare end stage renal dis-
11 ease prospective payment system under section
12 1881(b)(14) of the Social Security Act (42 U.S.C.
13 1395rr(b)(14)) for calendar year 2016, the Secretary of
14 Health and Human Services (in this subsection referred
15 to as the “Secretary”) shall establish a process for—

16 (1) determining when a product is no longer an
17 oral-only drug; and

18 (2) including new injectable and intravenous
19 products into the bundled payment under such sys-
20 tem.

21 (d) QUALITY MEASURES RELATED TO CONDITIONS
22 TREATED BY ORAL-ONLY DRUGS UNDER THE ESRD
23 QUALITY INCENTIVE PROGRAM.—Section 1881(h)(2) of
24 the Social Security Act (42 U.S.C. 1395rr(h)(2)) is
25 amended—

1 (1) in subparagraph (A)—

2 (A) in clause (ii), by striking “and” at the
3 end;

4 (B) by redesignating clause (iii) as clause
5 (iv); and

6 (C) by inserting after clause (ii) the fol-
7 lowing new clause:

8 “(iii) for 2016 and subsequent years,
9 measures described in subparagraph
10 (E)(i); and”;

11 (2) in subparagraph (B)(i), by striking
12 “(A)(iii)” and inserting “(A)(iv)”;

13 (3) by adding at the end the following new sub-
14 paragraph:

15 “(E) MEASURES SPECIFIC TO THE CONDI-
16 TIONS TREATED WITH ORAL-ONLY DRUGS.—

17 “(i) IN GENERAL.—The measures de-
18 scribed in this subparagraph are measures
19 specified by the Secretary that are specific
20 to the conditions treated with oral-only
21 drugs. To the extent feasible, such meas-
22 ures shall be outcomes-based measures.

23 “(ii) CONSULTATION.—In specifying
24 the measures under clause (i), the Sec-

retary shall consult with interested stakeholders.

“(iii) USE OF ENDORSED MEASURES.—

“(I) IN GENERAL.—Subject to subclause (I), any measures specified under clause (i) must have been endorsed by the entity with a contract under section 1890(a).

“(II) EXCEPTION.—If the entity with a contract under section 1890(a) has not endorsed a measure for a specified area or topic related to measures described in clause (i) that the Secretary determines appropriate, the Secretary may specify a measure that is endorsed or adopted by a consensus organization recognized by the Secretary that has expertise in clinical guidelines for kidney disease.”.

(e) AUDITS OF COST REPORTS OF ESRD PROVIDERS

AS RECOMMENDED BY MEDPAC.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct audits of Medicare cost reports beginning during 2012 for a representa-

1 tive sample of providers of services and renal dialysis
2 facilities furnishing renal dialysis services.

3 (2) FUNDING.—For purposes of carrying out
4 paragraph (1), the Secretary of Health and Human
5 Services shall provide for the transfer from the Fed-
6 eral Supplementary Medical Insurance Trust Fund
7 established under section 1841 of the Social Security
8 Act (42 U.S.C. 1395t) to the Centers for Medicare
9 & Medicaid Services Program Management Account
10 of \$18,000,000 for fiscal year 2014. Amounts trans-
11 ferred under this paragraph for a fiscal year shall be
12 available until expended.

13 **SEC. 218. QUALITY INCENTIVES FOR COMPUTED TOMOG-**
14 **RAPHY DIAGNOSTIC IMAGING AND PRO-**
15 **MOTING EVIDENCE-BASED CARE.**

16 (a) QUALITY INCENTIVES TO PROMOTE PATIENT
17 SAFETY AND PUBLIC HEALTH IN COMPUTED TOMOG-
18 RAPHY DIAGNOSTIC IMAGING.—

19 (1) IN GENERAL.—Section 1834 of the Social
20 Security Act (42 U.S.C. 1395m) is amended by add-
21 ing at the end the following new subsection:

22 “(p) QUALITY INCENTIVES TO PROMOTE PATIENT
23 SAFETY AND PUBLIC HEALTH IN COMPUTED TOMOG-
24 RAPHY.—

1 “(1) QUALITY INCENTIVES.—In the case of an
2 applicable computed tomography service (as defined
3 in paragraph (2)) for which payment is made under
4 an applicable payment system (as defined in para-
5 graph (3)) and that is furnished on or after January
6 1, 2016, using equipment that is not consistent with
7 the CT equipment standard (described in paragraph
8 (4)), the payment amount for such service shall be
9 reduced by the applicable percentage (as defined in
10 paragraph (5)).

11 “(2) APPLICABLE COMPUTED TOMOGRAPHY
12 SERVICES DEFINED.—In this subsection, the term
13 ‘applicable computed tomography service’ means a
14 service billed using diagnostic radiological imaging
15 codes for computed tomography (identified as of
16 January 1, 2014, by HCPCS codes 70450–70498,
17 71250–71275, 72125–72133, 72191–72194, 73200–
18 73206, 73700–73706, 74150–74178, 74261–74263,
19 and 75571–75574 (and any succeeding codes)).

20 “(3) APPLICABLE PAYMENT SYSTEM DE-
21 FINED.—In this subsection, the term ‘applicable
22 payment system’ means the following:

23 “(A) The technical component and the
24 technical component of the global fee under the
25 fee schedule established under section 1848(b).

1 “(B) The prospective payment system for
2 hospital outpatient department services under
3 section 1833(t).

4 “(4) CONSISTENCY WITH CT EQUIPMENT
5 STANDARD.—In this subsection, the term ‘not con-
6 sistent with the CT equipment standard’ means,
7 with respect to an applicable computed tomography
8 service, that the service was furnished using equip-
9 ment that does not meet each of the attributes of
10 the National Electrical Manufacturers Association
11 (NEMA) Standard XR–29–2013, entitled ‘Standard
12 Attributes on CT Equipment Related to Dose Opti-
13 mization and Management’. Through rulemaking,
14 the Secretary may apply successor standards.

15 “(5) APPLICABLE PERCENTAGE DEFINED.—In
16 this subsection, the term ‘applicable percentage’
17 means—

18 “(A) for 2016, 5 percent; and

19 “(B) for 2017 and subsequent years, 15
20 percent.

21 “(6) IMPLEMENTATION.—

22 “(A) INFORMATION.—The Secretary shall
23 require that information be provided and at-
24 tested to by a supplier and a hospital outpatient
25 department that indicates whether an applicable

1 computed tomography service was furnished
 2 that was not consistent with the CT equipment
 3 standard (described in paragraph (4)). Such in-
 4 formation may be included on a claim and may
 5 be a modifier. Such information shall be
 6 verified, as appropriate, as part of the periodic
 7 accreditation of suppliers under section 1834(e)
 8 and hospitals under section 1865(a).

9 “(B) ADMINISTRATION.—Chapter 35 of
 10 title 44, United States Code, shall not apply to
 11 information described in subparagraph (A).”.

12 (2) CONFORMING AMENDMENTS.—

13 (A) PROSPECTIVE PAYMENT SYSTEM FOR
 14 HOSPITAL OUTPATIENT DEPARTMENT SERV-
 15 ICES.—Section 1833(t) of the Social Security
 16 Act (42 1395l(t)) is amended by adding at the
 17 end the following new paragraph:

18 “(20) NOT BUDGET NEUTRAL APPLICATION OF
 19 REDUCED EXPENDITURES RESULTING FROM QUAL-
 20 ITY INCENTIVES FOR COMPUTED TOMOGRAPHY.—
 21 The Secretary shall not take into account the re-
 22 duced expenditures that result from the application
 23 of section 1834(p) in making any budget neutrality
 24 adjustments this subsection.”.

1 (B) PHYSICIAN FEE SCHEDULE.—Section
 2 1848(c)(2)(B)(v) of the Social Security Act (42
 3 U.S.C. 1395w-4(c)(2)(B)(v)) is amended by
 4 adding at the end the following new subclause:

5 “(VIII) REDUCED EXPENDI-
 6 TURES ATTRIBUTABLE TO APPLICA-
 7 TION OF QUALITY INCENTIVES FOR
 8 COMPUTED TOMOGRAPHY.—Effective
 9 for fee schedules established beginning
 10 with 2016, reduced expenditures at-
 11 tributable to the application of the
 12 quality incentives for computed to-
 13 mography under section 1834(p)”.

14 (b) PROMOTING EVIDENCE-BASED CARE.—

15 (1) IN GENERAL.—Section 1834 of the Social
 16 Security Act (42 U.S.C. 1395m), as amended by
 17 subsection (a), is amended by adding at the end the
 18 following new subsection:

19 “(q) RECOGNIZING APPROPRIATE USE CRITERIA FOR
 20 CERTAIN IMAGING SERVICES.—

21 “(1) PROGRAM ESTABLISHED.—

22 “(A) IN GENERAL.—The Secretary shall
 23 establish a program to promote the use of ap-
 24 propriate use criteria (as defined in subpara-
 25 graph (B)) for applicable imaging services (as

1 defined in subparagraph (C)) furnished in an
2 applicable setting (as defined in subparagraph
3 (D)) by ordering professionals and furnishing
4 professionals (as defined in subparagraphs (E)
5 and (F), respectively).

6 “(B) APPROPRIATE USE CRITERIA DE-
7 FINED.—In this subsection, the term ‘appro-
8 priate use criteria’ means criteria, only devel-
9 oped or endorsed by national professional med-
10 ical specialty societies or other provider-led enti-
11 ties, to assist ordering professionals and fur-
12 nishing professionals in making the most appro-
13 priate treatment decision for a specific clinical
14 condition for an individual. To the extent fea-
15 sible, such criteria shall be evidence-based.

16 “(C) APPLICABLE IMAGING SERVICE DE-
17 FINED.—In this subsection, the term ‘applicable
18 imaging service’ means an advanced diagnostic
19 imaging service (as defined in subsection
20 (e)(1)(B)) for which the Secretary determines—

21 “(i) one or more applicable appro-
22 priate use criteria specified under para-
23 graph (2) apply;

1 “(ii) there are one or more qualified
2 clinical decision support mechanisms listed
3 under paragraph (3)(C); and

4 “(iii) one or more of such mechanisms
5 is available free of charge.

6 “(D) APPLICABLE SETTING DEFINED.—In
7 this subsection, the term ‘applicable setting’
8 means a physician’s office, a hospital outpatient
9 department (including an emergency depart-
10 ment), an ambulatory surgical center, and any
11 other provider-led outpatient setting determined
12 appropriate by the Secretary.

13 “(E) ORDERING PROFESSIONAL DE-
14 FINED.—In this subsection, the term ‘ordering
15 professional’ means a physician (as defined in
16 section 1861(r)) or a practitioner described in
17 section 1842(b)(18)(C) who orders an applica-
18 ble imaging service.

19 “(F) FURNISHING PROFESSIONAL DE-
20 FINED.—In this subsection, the term ‘fur-
21 nishing professional’ means a physician (as de-
22 fined in section 1861(r)) or a practitioner de-
23 scribed in section 1842(b)(18)(C) who furnishes
24 an applicable imaging service.

1 “(2) ESTABLISHMENT OF APPLICABLE APPRO-
2 PRIATE USE CRITERIA.—

3 “(A) IN GENERAL.—Not later than No-
4 vember 15, 2015, the Secretary shall through
5 rulemaking, and in consultation with physi-
6 cians, practitioners, and other stakeholders,
7 specify applicable appropriate use criteria for
8 applicable imaging services only from among
9 appropriate use criteria developed or endorsed
10 by national professional medical specialty soci-
11 eties or other provider-led entities.

12 “(B) CONSIDERATIONS.—In specifying ap-
13 plicable appropriate use criteria under subpara-
14 graph (A), the Secretary shall take into account
15 whether the criteria—

16 “(i) have stakeholder consensus;

17 “(ii) are scientifically valid and evi-
18 dence based; and

19 “(iii) are based on studies that are
20 published and reviewable by stakeholders.

21 “(C) REVISIONS.—The Secretary shall re-
22 view, on an annual basis, the specified applica-
23 ble appropriate use criteria to determine if
24 there is a need to update or revise (as appro-
25 priate) such specification of applicable appro-

1 priate use criteria and make such updates or
2 revisions through rulemaking.

3 “(D) TREATMENT OF MULTIPLE APPLICA-
4 BLE APPROPRIATE USE CRITERIA.—In the case
5 where the Secretary determines that more than
6 one appropriate use criterion applies with re-
7 spect to an applicable imaging service, the Sec-
8 retary shall apply one or more applicable appro-
9 priate use criteria under this paragraph for the
10 service.

11 “(3) MECHANISMS FOR CONSULTATION WITH
12 APPLICABLE APPROPRIATE USE CRITERIA.—

13 “(A) IDENTIFICATION OF MECHANISMS TO
14 CONSULT WITH APPLICABLE APPROPRIATE USE
15 CRITERIA.—

16 “(i) IN GENERAL.—The Secretary
17 shall specify qualified clinical decision sup-
18 port mechanisms that could be used by or-
19 dering professionals to consult with appli-
20 cable appropriate use criteria for applicable
21 imaging services.

22 “(ii) CONSULTATION.—The Secretary
23 shall consult with physicians, practitioners,
24 health care technology experts, and other

1 stakeholders in specifying mechanisms
2 under this paragraph.

3 “(iii) INCLUSION OF CERTAIN MECHA-
4 NISMS.—Mechanisms specified under this
5 paragraph may include any or all of the
6 following that meet the requirements de-
7 scribed in subparagraph (B)(ii):

8 “(I) Use of clinical decision sup-
9 port modules in certified EHR tech-
10 nology (as defined in section
11 1848(o)(4)).

12 “(II) Use of private sector clin-
13 ical decision support mechanisms that
14 are independent from certified EHR
15 technology, which may include use of
16 clinical decision support mechanisms
17 available from medical specialty orga-
18 nizations.

19 “(III) Use of a clinical decision
20 support mechanism established by the
21 Secretary.

22 “(B) QUALIFIED CLINICAL DECISION SUP-
23 PORT MECHANISMS.—

24 “(i) IN GENERAL.—For purposes of
25 this subsection, a qualified clinical decision

1 support mechanism is a mechanism that
2 the Secretary determines meets the re-
3 quirements described in clause (ii).

4 “(ii) REQUIREMENTS.—The require-
5 ments described in this clause are the fol-
6 lowing:

7 “(I) The mechanism makes avail-
8 able to the ordering professional appli-
9 cable appropriate use criteria specified
10 under paragraph (2) and the sup-
11 porting documentation for the applica-
12 ble imaging service ordered.

13 “(II) In the case where there is
14 more than one applicable appropriate
15 use criterion specified under such
16 paragraph for an applicable imaging
17 service, the mechanism indicates the
18 criteria that it uses for the service.

19 “(III) The mechanism determines
20 the extent to which an applicable im-
21 aging service ordered is consistent
22 with the applicable appropriate use
23 criteria so specified.

24 “(IV) The mechanism generates
25 and provides to the ordering profes-

1 sional a certification or documentation
2 that documents that the qualified clin-
3 ical decision support mechanism was
4 consulted by the ordering professional.

5 “(V) The mechanism is updated
6 on a timely basis to reflect revisions
7 to the specification of applicable ap-
8 propriate use criteria under such
9 paragraph.

10 “(VI) The mechanism meets pri-
11 vacy and security standards under ap-
12 plicable provisions of law.

13 “(VII) The mechanism performs
14 such other functions as specified by
15 the Secretary, which may include a re-
16 quirement to provide aggregate feed-
17 back to the ordering professional.

18 “(C) LIST OF MECHANISMS FOR CON-
19 SULTATION WITH APPLICABLE APPROPRIATE
20 USE CRITERIA.—

21 “(i) INITIAL LIST.—Not later than
22 April 1, 2016, the Secretary shall publish
23 a list of mechanisms specified under this
24 paragraph.

1 “(ii) PERIODIC UPDATING OF LIST.—

2 The Secretary shall identify on an annual
3 basis the list of qualified clinical decision
4 support mechanisms specified under this
5 paragraph.

6 “(4) CONSULTATION WITH APPLICABLE APPRO-
7 PRIATE USE CRITERIA.—

8 “(A) CONSULTATION BY ORDERING PRO-
9 FESSSIONAL.—Beginning with January 1, 2017,
10 subject to subparagraph (C), with respect to an
11 applicable imaging service ordered by an order-
12 ing professional that would be furnished in an
13 applicable setting and paid for under an appli-
14 cable payment system (as defined in subpara-
15 graph (D)), an ordering professional shall—

16 “(i) consult with a qualified decision
17 support mechanism listed under paragraph
18 (3)(C); and

19 “(ii) provide to the furnishing profes-
20 sional the information described in clauses
21 (i) through (iii) of subparagraph (B).

22 “(B) REPORTING BY FURNISHING PROFES-
23 SSIONAL.—Beginning with January 1, 2017,
24 subject to subparagraph (C), with respect to an
25 applicable imaging service furnished in an ap-

1 applicable setting and paid for under an applica-
2 ble payment system (as defined in subpara-
3 graph (D)), payment for such service may only
4 be made if the claim for the service includes the
5 following:

6 “(i) Information about which qualified
7 clinical decision support mechanism was
8 consulted by the ordering professional for
9 the service.

10 “(ii) Information regarding—

11 “(I) whether the service ordered
12 would adhere to the applicable appro-
13 priate use criteria specified under
14 paragraph (2);

15 “(II) whether the service ordered
16 would not adhere to such criteria; or

17 “(III) whether such criteria was
18 not applicable to the service ordered.

19 “(iii) The national provider identifier
20 of the ordering professional (if different
21 from the furnishing professional).

22 “(C) EXCEPTIONS.—The provisions of sub-
23 paragraphs (A) and (B) and paragraph (6)(A)
24 shall not apply to the following:

1 “(i) EMERGENCY SERVICES.—An ap-
2 plicable imaging service ordered for an in-
3 dividual with an emergency medical condi-
4 tion (as defined in section 1867(e)(1)).

5 “(ii) INPATIENT SERVICES.—An appli-
6 cable imaging service ordered for an inpa-
7 tient and for which payment is made under
8 part A.

9 “(iii) SIGNIFICANT HARDSHIP.—An
10 applicable imaging service ordered by an
11 ordering professional who the Secretary
12 may, on a case-by-case basis, exempt from
13 the application of such provisions if the
14 Secretary determines, subject to annual re-
15 newal, that consultation with applicable ap-
16 propriate use criteria would result in a sig-
17 nificant hardship, such as in the case of a
18 professional who practices in a rural area
19 without sufficient Internet access.

20 “(D) APPLICABLE PAYMENT SYSTEM DE-
21 FINED.—In this subsection, the term ‘applicable
22 payment system’ means the following:

23 “(i) The physician fee schedule estab-
24 lished under section 1848(b).

1 “(ii) The prospective payment system
2 for hospital outpatient department services
3 under section 1833(t).

4 “(iii) The ambulatory surgical center
5 payment systems under section 1833(i).

6 “(5) IDENTIFICATION OF OUTLIER ORDERING
7 PROFESSIONALS.—

8 “(A) IN GENERAL.—With respect to appli-
9 cable imaging services furnished beginning with
10 2017, the Secretary shall determine, on an an-
11 nual basis, no more than five percent of the
12 total number of ordering professionals who are
13 outlier ordering professionals.

14 “(B) OUTLIER ORDERING PROFES-
15 SIONALS.—The determination of an outlier or-
16 dering professional shall—

17 “(i) be based on low adherence to ap-
18 plicable appropriate use criteria specified
19 under paragraph (2), which may be based
20 on comparison to other ordering profes-
21 sionals; and

22 “(ii) include data for ordering profes-
23 sionals for whom prior authorization under
24 paragraph (6)(A) applies.

1 “(C) USE OF TWO YEARS OF DATA.—The
2 Secretary shall use two years of data to identify
3 outlier ordering professionals under this para-
4 graph.

5 “(D) PROCESS.—The Secretary shall es-
6 tablish a process for determining when an
7 outlier ordering professional is no longer an
8 outlier ordering professional.

9 “(E) CONSULTATION WITH STAKE-
10 HOLDERS.—The Secretary shall consult with
11 physicians, practitioners and other stakeholders
12 in developing methods to identify outlier order-
13 ing professionals under this paragraph.

14 “(6) PRIOR AUTHORIZATION FOR ORDERING
15 PROFESSIONALS WHO ARE OUTLIERS.—

16 “(A) IN GENERAL.—Beginning January 1,
17 2020, subject to paragraph (4)(C), with respect
18 to services furnished during a year, the Sec-
19 retary shall, for a period determined appro-
20 priate by the Secretary, apply prior authoriza-
21 tion for applicable imaging services that are or-
22 dered by an outlier ordering professional identi-
23 fied under paragraph (5).

24 “(B) APPROPRIATE USE CRITERIA IN
25 PRIOR AUTHORIZATION.—In applying prior au-

1 thorization under subparagraph (A), the Sec-
2 retary shall utilize only the applicable appro-
3 priate use criteria specified under this sub-
4 section.

5 “(C) FUNDING.—For purposes of carrying
6 out this paragraph, the Secretary shall provide
7 for the transfer, from the Federal Supple-
8 mentary Medical Insurance Trust Fund under
9 section 1841, of \$5,000,000 to the Centers for
10 Medicare & Medicaid Services Program Man-
11 agement Account for each of fiscal years 2019
12 through 2021. Amounts transferred under the
13 preceding sentence shall remain available until
14 expended.

15 “(7) CONSTRUCTION.—Nothing in this sub-
16 section shall be construed as granting the Secretary
17 the authority to develop or initiate the development
18 of clinical practice guidelines or appropriate use cri-
19 teria.”.

20 (2) CONFORMING AMENDMENT.—Section
21 1833(t)(16) of the Social Security Act (42 U.S.C.
22 1395l(t)(16)) is amended by adding at the end the
23 following new subparagraph:

24 “(E) APPLICATION OF APPROPRIATE USE
25 CRITERIA FOR CERTAIN IMAGING SERVICES.—

1 For provisions relating to the application of ap-
 2 propriate use criteria for certain imaging serv-
 3 ices, see section 1834(q).”.

4 (3) REPORT ON EXPERIENCE OF IMAGING AP-
 5 PROPRIATE USE CRITERIA PROGRAM.—Not later
 6 than 18 months after the date of the enactment of
 7 this Act, the Comptroller General of the United
 8 States shall submit to Congress a report that in-
 9 cludes a description of the extent to which appro-
 10 priate use criteria could be used for other services
 11 under part B of title XVIII of the Social Security
 12 Act (42 U.S.C. 1395j et seq.), such as radiation
 13 therapy and clinical diagnostic laboratory services.

14 **SEC. 219. USING FUNDING FROM TRANSITIONAL FUND FOR**
 15 **SUSTAINABLE GROWTH RATE (SGR) REFORM.**

16 Section 1898(b)(1) of the Social Security Act (42
 17 U.S.C. 1395iii(b)(1)) is amended by striking
 18 “\$2,300,000,000” and inserting “\$0”.

19 **SEC. 220. ENSURING ACCURATE VALUATION OF SERVICES**
 20 **UNDER THE PHYSICIAN FEE SCHEDULE.**

21 (a) AUTHORITY TO COLLECT AND USE INFORMA-
 22 TION ON PHYSICIANS’ SERVICES IN THE DETERMINATION
 23 OF RELATIVE VALUES.—

24 (1) IN GENERAL.—Section 1848(c)(2) of the
 25 Social Security Act (42 U.S.C. 1395w–4(c)(2)) is

1 amended by adding at the end the following new
2 subparagraph:

3 “(M) AUTHORITY TO COLLECT AND USE
4 INFORMATION ON PHYSICIANS’ SERVICES IN
5 THE DETERMINATION OF RELATIVE VALUES.—

6 “(i) COLLECTION OF INFORMATION.—
7 Notwithstanding any other provision of
8 law, the Secretary may collect or obtain in-
9 formation on the resources directly or indi-
10 rectly related to furnishing services for
11 which payment is made under the fee
12 schedule established under subsection (b).
13 Such information may be collected or ob-
14 tained from any eligible professional or any
15 other source.

16 “(ii) USE OF INFORMATION.—Not-
17 withstanding any other provision of law,
18 subject to clause (v), the Secretary may
19 (as the Secretary determines appropriate)
20 use information collected or obtained pur-
21 suant to clause (i) in the determination of
22 relative values for services under this sec-
23 tion.

24 “(iii) TYPES OF INFORMATION.—The
25 types of information described in clauses

1 (i) and (ii) may, at the Secretary's discre-
2 tion, include any or all of the following:

3 “(I) Time involved in furnishing
4 services.

5 “(II) Amounts and types of prac-
6 tice expense inputs involved with fur-
7 nishing services.

8 “(III) Prices (net of any dis-
9 counts) for practice expense inputs,
10 which may include paid invoice prices
11 or other documentation or records.

12 “(IV) Overhead and accounting
13 information for practices of physicians
14 and other suppliers.

15 “(V) Any other element that
16 would improve the valuation of serv-
17 ices under this section.

18 “(iv) INFORMATION COLLECTION
19 MECHANISMS.—Information may be col-
20 lected or obtained pursuant to this sub-
21 paragraph from any or all of the following:

22 “(I) Surveys of physicians, other
23 suppliers, providers of services, manu-
24 facturers, and vendors.

1 “(II) Surgical logs, billing sys-
2 tems, or other practice or facility
3 records.

4 “(III) Electronic health records.

5 “(IV) Any other mechanism de-
6 termined appropriate by the Sec-
7 retary.

8 “(V) TRANSPARENCY OF USE OF IN-
9 FORMATION.—

10 “(I) IN GENERAL.—Subject to
11 subclauses (II) and (III), if the Sec-
12 retary uses information collected or
13 obtained under this subparagraph in
14 the determination of relative values
15 under this subsection, the Secretary
16 shall disclose the information source
17 and discuss the use of such informa-
18 tion in such determination of relative
19 values through notice and comment
20 rulemaking.

21 “(II) THRESHOLDS FOR USE.—
22 The Secretary may establish thresh-
23 olds in order to use such information,
24 including the exclusion of information
25 collected or obtained from eligible pro-

1 professionals who use very high resources
2 (as determined by the Secretary) in
3 furnishing a service.

4 “(III) DISCLOSURE OF INFORMA-
5 TION.—The Secretary shall make ag-
6 gregate information available under
7 this subparagraph but shall not dis-
8 close information in a form or manner
9 that identifies an eligible professional
10 or a group practice, or information
11 collected or obtained pursuant to a
12 nondisclosure agreement.

13 “(vi) INCENTIVE TO PARTICIPATE.—
14 The Secretary may provide for such pay-
15 ments under this part to an eligible profes-
16 sional that submits such solicited informa-
17 tion under this subparagraph as the Sec-
18 retary determines appropriate in order to
19 compensate such eligible professional for
20 such submission. Such payments shall be
21 provided in a form and manner specified
22 by the Secretary.

23 “(vii) ADMINISTRATION.—Chapter 35
24 of title 44, United States Code, shall not

1 apply to information collected or obtained
2 under this subparagraph.

3 “(viii) DEFINITION OF ELIGIBLE PRO-
4 FESSIOAL.—In this subparagraph, the
5 term ‘eligible professional’ has the meaning
6 given such term in subsection (k)(3)(B).

7 “(ix) FUNDING.—For purposes of car-
8 rying out this subparagraph, in addition to
9 funds otherwise appropriated, the Sec-
10 retary shall provide for the transfer, from
11 the Federal Supplementary Medical Insur-
12 ance Trust Fund under section 1841, of
13 \$2,000,000 to the Centers for Medicare &
14 Medicaid Services Program Management
15 Account for each fiscal year beginning with
16 fiscal year 2014. Amounts transferred
17 under the preceding sentence for a fiscal
18 year shall be available until expended.”.

19 (2) LIMITATION ON REVIEW.—Section
20 1848(i)(1) of the Social Security Act (42 U.S.C.
21 1395w-4(i)(1)) is amended—

22 (A) in subparagraph (D), by striking
23 “and” at the end;

24 (B) in subparagraph (E), by striking the
25 period at the end and inserting “, and”; and

1 (C) by adding at the end the following new
2 subparagraph:

3 “(F) the collection and use of information
4 in the determination of relative values under
5 subsection (c)(2)(M).”.

6 (b) AUTHORITY FOR ALTERNATIVE APPROACHES TO
7 ESTABLISHING PRACTICE EXPENSE RELATIVE VAL-
8 UES.—Section 1848(c)(2) of the Social Security Act (42
9 U.S.C. 1395w-4(c)(2)), as amended by subsection (a), is
10 amended by adding at the end the following new subpara-
11 graph:

12 “(N) AUTHORITY FOR ALTERNATIVE AP-
13 PROACHES TO ESTABLISHING PRACTICE EX-
14 PENSE RELATIVE VALUES.—The Secretary may
15 establish or adjust practice expense relative val-
16 ues under this subsection using cost, charge, or
17 other data from suppliers or providers of serv-
18 ices, including information collected or obtained
19 under subparagraph (M).”.

20 (c) REVISED AND EXPANDED IDENTIFICATION OF
21 POTENTIALLY MISVALUED CODES.—Section
22 1848(c)(2)(K)(ii) of the Social Security Act (42 U.S.C.
23 1395w-4(c)(2)(K)(ii)) is amended to read as follows:

24 “(ii) IDENTIFICATION OF POTEN-
25 Tially MISVALUED CODES.—For purposes

1 of identifying potentially misvalued codes
2 pursuant to clause (i)(I), the Secretary
3 shall examine codes (and families of codes
4 as appropriate) based on any or all of the
5 following criteria:

6 “(I) Codes that have experienced
7 the fastest growth.

8 “(II) Codes that have experi-
9 enced substantial changes in practice
10 expenses.

11 “(III) Codes that describe new
12 technologies or services within an ap-
13 propriate time period (such as 3
14 years) after the relative values are ini-
15 tially established for such codes.

16 “(IV) Codes which are multiple
17 codes that are frequently billed in con-
18 junction with furnishing a single serv-
19 ice.

20 “(V) Codes with low relative val-
21 ues, particularly those that are often
22 billed multiple times for a single treat-
23 ment.

1 “(VI) Codes that have not been
2 subject to review since implementation
3 of the fee schedule.

4 “(VII) Codes that account for
5 the majority of spending under the
6 physician fee schedule.

7 “(VIII) Codes for services that
8 have experienced a substantial change
9 in the hospital length of stay or proce-
10 dure time.

11 “(IX) Codes for which there may
12 be a change in the typical site of serv-
13 ice since the code was last valued.

14 “(X) Codes for which there is a
15 significant difference in payment for
16 the same service between different
17 sites of service.

18 “(XI) Codes for which there may
19 be anomalies in relative values within
20 a family of codes.

21 “(XII) Codes for services where
22 there may be efficiencies when a serv-
23 ice is furnished at the same time as
24 other services.

1 “(XIII) Codes with high intra-
2 service work per unit of time.

3 “(XIV) Codes with high practice
4 expense relative value units.

5 “(XV) Codes with high cost sup-
6 plies.

7 “(XVI) Codes as determined ap-
8 propriate by the Secretary.”.

9 (d) TARGET FOR RELATIVE VALUE ADJUSTMENTS
10 FOR MISVALUED SERVICES.—

11 (1) IN GENERAL.—Section 1848(c)(2) of the
12 Social Security Act (42 U.S.C. 1395w–4(c)(2)), as
13 amended by subsections (a) and (b), is amended by
14 adding at the end the following new subparagraph:

15 “(O) TARGET FOR RELATIVE VALUE AD-
16 JUSTMENTS FOR MISVALUED SERVICES.—With
17 respect to fee schedules established for each of
18 2017 through 2020, the following shall apply:

19 “(i) DETERMINATION OF NET REDUC-
20 TION IN EXPENDITURES.—For each year,
21 the Secretary shall determine the esti-
22 mated net reduction in expenditures under
23 the fee schedule under this section with re-
24 spect to the year as a result of adjust-

1 ments to the relative values established
2 under this paragraph for misvalued codes.

3 “(ii) BUDGET NEUTRAL REDISTRIBU-
4 TION OF FUNDS IF TARGET MET AND
5 COUNTING OVERAGES TOWARDS THE TAR-
6 GET FOR THE SUCCEEDING YEAR.—If the
7 estimated net reduction in expenditures de-
8 termined under clause (i) for the year is
9 equal to or greater than the target for the
10 year—

11 “(I) reduced expenditures attrib-
12 utable to such adjustments shall be
13 redistributed for the year in a budget
14 neutral manner in accordance with
15 subparagraph (B)(ii)(II); and

16 “(II) the amount by which such
17 reduced expenditures exceeds the tar-
18 get for the year shall be treated as a
19 reduction in expenditures described in
20 clause (i) for the succeeding year, for
21 purposes of determining whether the
22 target has or has not been met under
23 this subparagraph with respect to that
24 year.

1 “(iii) EXEMPTION FROM BUDGET
2 NEUTRALITY IF TARGET NOT MET.—If the
3 estimated net reduction in expenditures de-
4 termined under clause (i) for the year is
5 less than the target for the year, reduced
6 expenditures in an amount equal to the
7 target recapture amount shall not be taken
8 into account in applying subparagraph
9 (B)(ii)(II) with respect to fee schedules be-
10 ginning with 2017.

11 “(iv) TARGET RECAPTURE AMOUNT.—
12 For purposes of clause (iii), the target re-
13 capture amount is, with respect to a year,
14 an amount equal to the difference be-
15 tween—

16 “(I) the target for the year; and
17 “(II) the estimated net reduction
18 in expenditures determined under
19 clause (i) for the year.

20 “(v) TARGET.—For purposes of this
21 subparagraph, with respect to a year, the
22 target is calculated as 0.5 percent of the
23 estimated amount of expenditures under
24 the fee schedule under this section for the
25 year.”.

1 (2) CONFORMING AMENDMENT.—Section
 2 1848(c)(2)(B)(v) of the Social Security Act (42
 3 U.S.C. 1395w–4(c)(2)(B)(v)) is amended by adding
 4 at the end the following new subclause:

5 “(VIII) REDUCTIONS FOR
 6 MISVALUED SERVICES IF TARGET NOT
 7 MET.—Effective for fee schedules be-
 8 ginning with 2017, reduced expendi-
 9 tures attributable to the application of
 10 the target recapture amount described
 11 in subparagraph (O)(iii).”.

12 (e) PHASE-IN OF SIGNIFICANT RELATIVE VALUE
 13 UNIT (RVU) REDUCTIONS.—

14 (1) IN GENERAL.—Section 1848(c) of the So-
 15 cial Security Act (42 U.S.C. 1395w–4(c)) is amend-
 16 ed by adding at the end the following new para-
 17 graph:

18 “(7) PHASE-IN OF SIGNIFICANT RELATIVE
 19 VALUE UNIT (RVU) REDUCTIONS.—Effective for fee
 20 schedules established beginning with 2017, for serv-
 21 ices that are not new or revised codes, if the total
 22 relative value units for a service for a year would
 23 otherwise be decreased by an estimated amount
 24 equal to or greater than 20 percent as compared to
 25 the total relative value units for the previous year,

1 the applicable adjustments in work, practice expense,
 2 and malpractice relative value units shall be phased-
 3 in over a 2-year period.”.

4 (2) CONFORMING AMENDMENTS.—Section
 5 1848(c)(2) of the Social Security Act (42 U.S.C.
 6 1395w-4(c)(2)) is amended—

7 (A) in subparagraph (B)(ii)(I), by striking
 8 “subclause (II)” and inserting “subclause (II)
 9 and paragraph (7)”; and

10 (B) in subparagraph (K)(iii)(VI)—

11 (i) by striking “provisions of subpara-
 12 graph (B)(ii)(II)” and inserting “provi-
 13 sions of subparagraph (B)(ii)(II) and para-
 14 graph (7)”; and

15 (ii) by striking “under subparagraph
 16 (B)(ii)(II)” and inserting “under subpara-
 17 graph (B)(ii)(I)”.

18 (f) AUTHORITY TO SMOOTH RELATIVE VALUES
 19 WITHIN GROUPS OF SERVICES.—Section 1848(c)(2)(C) of
 20 the Social Security Act (42 U.S.C. 1395w-4(c)(2)(C)) is
 21 amended—

22 (1) in each of clauses (i) and (iii), by striking
 23 “the service” and inserting “the service or group of
 24 services” each place it appears; and

1 (2) in the first sentence of clause (ii), by insert-
2 ing “or group of services” before the period.

3 (g) GAO STUDY AND REPORT ON RELATIVE VALUE
4 SCALE UPDATE COMMITTEE.—

5 (1) STUDY.—The Comptroller General of the
6 United States (in this subsection referred to as the
7 “Comptroller General”) shall conduct a study of the
8 processes used by the Relative Value Scale Update
9 Committee (RUC) to provide recommendations to
10 the Secretary of Health and Human Services regard-
11 ing relative values for specific services under the
12 Medicare physician fee schedule under section 1848
13 of the Social Security Act (42 U.S.C. 1395w–4).

14 (2) REPORT.—Not later than 1 year after the
15 date of the enactment of this Act, the Comptroller
16 General shall submit to Congress a report containing
17 the results of the study conducted under paragraph
18 (1).

19 (h) ADJUSTMENT TO MEDICARE PAYMENT LOCAL-
20 ITIES.—

21 (1) IN GENERAL.—Section 1848(e) of the So-
22 cial Security Act (42 U.S.C. 1395w–4(e)) is amend-
23 ed by adding at the end the following new para-
24 graph:

1 “(6) USE OF MSAS AS FEE SCHEDULE AREAS IN
2 CALIFORNIA.—

3 “(A) IN GENERAL.—Subject to the suc-
4 ceeding provisions of this paragraph and not-
5 withstanding the previous provisions of this
6 subsection, for services furnished on or after
7 January 1, 2017, the fee schedule areas used
8 for payment under this section applicable to
9 California shall be the following:

10 “(i) Each Metropolitan Statistical
11 Area (each in this paragraph referred to as
12 an ‘MSA’), as defined by the Director of
13 the Office of Management and Budget as
14 of December 31 of the previous year, shall
15 be a fee schedule area.

16 “(ii) All areas not included in an MSA
17 shall be treated as a single rest-of-State
18 fee schedule area.

19 “(B) TRANSITION FOR MSAS PREVIOUSLY
20 IN REST-OF-STATE PAYMENT LOCALITY OR IN
21 LOCALITY 3.—

22 “(i) IN GENERAL.—For services fur-
23 nished in California during a year begin-
24 ning with 2017 and ending with 2021 in
25 an MSA in a transition area (as defined in

1 subparagraph (D)), subject to subpara-
2 graph (C), the geographic index values to
3 be applied under this subsection for such
4 year shall be equal to the sum of the fol-
5 lowing:

6 “(I) CURRENT LAW COMPO-
7 NENT.—The old weighting factor (de-
8 scribed in clause (ii)) for such year
9 multiplied by the geographic index
10 values under this subsection for the
11 fee schedule area that included such
12 MSA that would have applied in such
13 area (as estimated by the Secretary)
14 if this paragraph did not apply.

15 “(II) MSA-BASED COMPO-
16 NENT.—The MSA-based weighting
17 factor (described in clause (iii)) for
18 such year multiplied by the geographic
19 index values computed for the fee
20 schedule area under subparagraph (A)
21 for the year (determined without re-
22 gard to this subparagraph).

23 “(ii) OLD WEIGHTING FACTOR.—The
24 old weighting factor described in this
25 clause—

1 “(I) for 2017, is $\frac{5}{6}$; and

2 “(II) for each succeeding year, is
3 the old weighting factor described in
4 this clause for the previous year
5 minus $\frac{1}{6}$.

6 “(iii) MSA-BASED WEIGHTING FAC-
7 TOR.—The MSA-based weighting factor
8 described in this clause for a year is 1
9 minus the old weighting factor under
10 clause (ii) for that year.

11 “(C) HOLD HARMLESS.—For services fur-
12 nished in a transition area in California during
13 a year beginning with 2017, the geographic
14 index values to be applied under this subsection
15 for such year shall not be less than the cor-
16 responding geographic index values that would
17 have applied in such transition area (as esti-
18 mated by the Secretary) if this paragraph did
19 not apply.

20 “(D) TRANSITION AREA DEFINED.—In
21 this paragraph, the term ‘transition area’
22 means each of the following fee schedule areas
23 for 2013:

24 “(i) The rest-of-State payment local-
25 ity.

1 “(ii) Payment locality 3.

2 “(E) REFERENCES TO FEE SCHEDULE
3 AREAS.—Effective for services furnished on or
4 after January 1, 2017, for California, any ref-
5 erence in this section to a fee schedule area
6 shall be deemed a reference to a fee schedule
7 area established in accordance with this para-
8 graph.”.

9 (2) CONFORMING AMENDMENT TO DEFINITION
10 OF FEE SCHEDULE AREA.—Section 1848(j)(2) of the
11 Social Security Act (42 U.S.C. 1395w–4(j)(2)) is
12 amended by striking “The term” and inserting “Ex-
13 cept as provided in subsection (e)(6)(D), the term”.

14 (i) DISCLOSURE OF DATA USED TO ESTABLISH
15 MULTIPLE PROCEDURE PAYMENT REDUCTION POLICY.—
16 The Secretary of Health and Human Services shall make
17 publicly available the information used to establish the
18 multiple procedure payment reduction policy to the profes-
19 sional component of imaging services in the final rule pub-
20 lished in the Federal Register, v. 77, n. 222, November
21 16, 2012, pages 68891–69380 under the physician fee
22 schedule under section 1848 of the Social Security Act (42
23 U.S.C. 1395w–4).

1 **SEC. 221. MEDICAID DSH.**

2 (a) MODIFICATIONS OF REDUCTIONS TO ALLOT-
3 MENTS.—Section 1923(f) of the Social Security Act (42
4 U.S.C. 1396r–4(f)) is amended—

5 (1) in paragraph (7)(A)—

6 (A) in clause (i), by striking “2016
7 through 2020” and inserting “2017 through
8 2024”; and

9 (B) in clause (ii), by striking subclauses
10 (I) through (IV), and inserting the following:

11 “(I) \$1,800,000,000 for fiscal
12 year 2017;

13 “(II) \$4,700,000,000 for fiscal
14 year 2018;

15 “(III) \$4,700,000,000 for fiscal
16 year 2019;

17 “(IV) \$4,700,000,000 for fiscal
18 year 2020;

19 “(V) \$4,800,000,000 for fiscal
20 year 2021;

21 “(VI) \$5,000,000,000 for fiscal
22 year 2022;

23 “(VII) \$5,000,000,000 for fiscal
24 year 2023; and

25 “(VIII) \$4,400,000,000 for fiscal
26 year 2024.”; and

1 (2) by striking paragraph (8) and inserting the
2 following:

3 “(8) CALCULATION OF DSH ALLOTMENTS
4 AFTER REDUCTIONS PERIOD.—The DSH allotment
5 for a State for fiscal years after fiscal year 2024
6 shall be calculated under paragraph (3) without re-
7 gard to paragraph (7).”.

8 (b) MACPAC REVIEW AND REPORT.—Section
9 1900(b)(6) of the Social Security Act (42 U.S.C.
10 1396(b)(6)) is amended—

11 (1) by striking “MACPAC shall consult” and
12 inserting the following:

13 “(A) IN GENERAL.—MACPAC shall con-
14 sult”; and

15 (2) by adding at the end the following:

16 “(B) REVIEW AND REPORTS REGARDING
17 MEDICAID DSH.—

18 “(i) IN GENERAL.—MACPAC shall
19 review and submit an annual report to
20 Congress on disproportionate share hos-
21 pital payments under section 1923. Each
22 report shall include the information speci-
23 fied in clause (ii).

1 “(ii) REQUIRED REPORT INFORMA-
2 TION.—Each report required under this
3 subparagraph shall include the following:

4 “(I) Data relating to changes in
5 the number of uninsured individuals.

6 “(II) Data relating to the
7 amount and sources of hospitals’ un-
8 compensated care costs, including the
9 amount of such costs that are the re-
10 sult of providing unreimbursed or
11 under-reimbursed services, charity
12 care, or bad debt.

13 “(III) Data identifying hospitals
14 with high levels of uncompensated
15 care that also provide access to essen-
16 tial community services for low-in-
17 come, uninsured, and vulnerable popu-
18 lations, such as graduate medical edu-
19 cation, and the continuum of primary
20 through quaternary care, including
21 the provision of trauma care and pub-
22 lic health services.

23 “(IV) State-specific analyses re-
24 garding the relationship between the
25 most recent State DSH allotment and

1 the projected State DSH allotment for
2 the succeeding year and the data re-
3 ported under subclauses (I), (II), and
4 (III) for the State.

5 “(iii) DATA.—Notwithstanding any
6 other provision of law, the Secretary regu-
7 larly shall provide MACPAC with the most
8 recent State reports and most recent inde-
9 pendent certified audits submitted under
10 section 1923(j), cost reports submitted
11 under title XVIII, and such other data as
12 MACPAC may request for purposes of con-
13 ducting the reviews and preparing and sub-
14 mitting the annual reports required under
15 this subparagraph.

16 “(iv) SUBMISSION DEADLINES.—The
17 first report required under this subpara-
18 graph shall be submitted to Congress not
19 later than February 1, 2016. Subsequent
20 reports shall be submitted as part of, or
21 with, each annual report required under
22 paragraph (1)(C) during the period of fis-
23 cal years 2017 through 2024.”.

1 **SEC. 222. REALIGNMENT OF THE MEDICARE SEQUESTER**
2 **FOR FISCAL YEAR 2024.**

3 Paragraph (6) (relating to implementing direct
4 spending reductions) of section 251A of the Balanced
5 Budget and Emergency Deficit Control Act of 1985 (2
6 U.S.C. 901a) is amended by adding at the end the fol-
7 lowing new subparagraph:

8 “(D) Notwithstanding the 2 percent limit speci-
9 fied in subparagraph (A) for payments for the Medi-
10 care programs specified in section 256(d), the se-
11 questration order of the President under such sub-
12 paragraph for fiscal year 2024 shall be applied to
13 such payments so that—

14 “(i) with respect to the first 6 months in
15 which such order is effective for such fiscal
16 year, the payment reduction shall be 4.0 per-
17 cent; and

18 “(ii) with respect to the second 6 months
19 in which such order is so effective for such fis-
20 cal year, the payment reduction shall be 0.0
21 percent.”.

22 **SEC. 223. DEMONSTRATION PROGRAMS TO IMPROVE COM-**
23 **MUNITY MENTAL HEALTH SERVICES.**

24 (a) CRITERIA FOR CERTIFIED COMMUNITY BEHAV-
25 IORAL HEALTH CLINICS TO PARTICIPATE IN DEM-
26 ONSTRATION PROGRAMS.—

1 (1) PUBLICATION.—Not later than September
2 1, 2015, the Secretary shall publish criteria for a
3 clinic to be certified by a State as a certified com-
4 munity behavioral health clinic for purposes of par-
5 ticipating in a demonstration program conducted
6 under subsection (d).

7 (2) REQUIREMENTS.—The criteria published
8 under this subsection shall include criteria with re-
9 spect to the following:

10 (A) STAFFING.—Staffing requirements, in-
11 cluding criteria that staff have diverse discipli-
12 nary backgrounds, have necessary State-re-
13 quired license and accreditation, and are cul-
14 turally and linguistically trained to serve the
15 needs of the clinic’s patient population.

16 (B) AVAILABILITY AND ACCESSIBILITY OF
17 SERVICES.—Availability and accessibility of
18 services, including crisis management services
19 that are available and accessible 24 hours a
20 day, the use of a sliding scale for payment, and
21 no rejection for services or limiting of services
22 on the basis of a patient’s ability to pay or a
23 place of residence.

24 (C) CARE COORDINATION.—Care coordina-
25 tion, including requirements to coordinate care

1 across settings and providers to ensure seamless
2 transitions for patients across the full spectrum
3 of health services including acute, chronic, and
4 behavioral health needs. Care coordination re-
5 quirements shall include partnerships or formal
6 contracts with the following:

7 (i) Federally-qualified health centers
8 (and as applicable, rural health clinics) to
9 provide Federally-qualified health center
10 services (and as applicable, rural health
11 clinic services) to the extent such services
12 are not provided directly through the cer-
13 tified community behavioral health clinic.

14 (ii) Inpatient psychiatric facilities and
15 substance use detoxification, post-detoxi-
16 fication step-down services, and residential
17 programs.

18 (iii) Other community or regional
19 services, supports, and providers, including
20 schools, child welfare agencies, juvenile and
21 criminal justice agencies and facilities, In-
22 dian Health Service youth regional treat-
23 ment centers, State licensed and nationally
24 accredited child placing agencies for thera-

1 peutic foster care service, and other social
2 and human services.

3 (iv) Department of Veterans Affairs
4 medical centers, independent outpatient
5 clinics, drop-in centers, and other facilities
6 of the Department as defined in section
7 1801 of title 38, United States Code.

8 (v) Inpatient acute care hospitals and
9 hospital outpatient clinics.

10 (D) SCOPE OF SERVICES.—Provision (in a
11 manner reflecting person-centered care) of the
12 following services which, if not available directly
13 through the certified community behavioral
14 health clinic, are provided or referred through
15 formal relationships with other providers:

16 (i) Crisis mental health services, in-
17 cluding 24-hour mobile crisis teams, emer-
18 gency crisis intervention services, and cri-
19 sis stabilization.

20 (ii) Screening, assessment, and diag-
21 nosis, including risk assessment.

22 (iii) Patient-centered treatment plan-
23 ning or similar processes, including risk as-
24 sessment and crisis planning.

1 (iv) Outpatient mental health and
2 substance use services.

3 (v) Outpatient clinic primary care
4 screening and monitoring of key health in-
5 dicators and health risk.

6 (vi) Targeted case management.

7 (vii) Psychiatric rehabilitation serv-
8 ices.

9 (viii) Peer support and counselor serv-
10 ices and family supports.

11 (ix) Intensive, community-based men-
12 tal health care for members of the armed
13 forces and veterans, particularly those
14 members and veterans located in rural
15 areas, provided the care is consistent with
16 minimum clinical mental health guidelines
17 promulgated by the Veterans Health Ad-
18 ministration including clinical guidelines
19 contained in the Uniform Mental Health
20 Services Handbook of such Administration.

21 (E) QUALITY AND OTHER REPORTING.—
22 Reporting of encounter data, clinical outcomes
23 data, quality data, and such other data as the
24 Secretary requires.

1 (F) ORGANIZATIONAL AUTHORITY.—Cri-
2 teria that a clinic be a non-profit or part of a
3 local government behavioral health authority or
4 operated under the authority of the Indian
5 Health Service, an Indian tribe or tribal organi-
6 zation pursuant to a contract, grant, coopera-
7 tive agreement, or compact with the Indian
8 Health Service pursuant to the Indian Self-De-
9 termination Act (25 U.S.C. 450 et seq.), or an
10 urban Indian organization pursuant to a grant
11 or contract with the Indian Health Service
12 under title V of the Indian Health Care Im-
13 provement Act (25 U.S.C. 1601 et seq.).

14 (b) GUIDANCE ON DEVELOPMENT OF PROSPECTIVE
15 PAYMENT SYSTEM FOR TESTING UNDER DEMONSTRA-
16 TION PROGRAMS.—

17 (1) IN GENERAL.—Not later than September 1,
18 2015, the Secretary, through the Administrator of
19 the Centers for Medicare & Medicaid Services, shall
20 issue guidance for the establishment of a prospective
21 payment system that shall only apply to medical as-
22 sistance for mental health services furnished by a
23 certified community behavioral health clinic partici-
24 pating in a demonstration program under subsection
25 (d).

1 (2) REQUIREMENTS.—The guidance issued by
2 the Secretary under paragraph (1) shall provide
3 that—

4 (A) no payment shall be made for inpatient
5 care, residential treatment, room and board ex-
6 penses, or any other non-ambulatory services,
7 as determined by the Secretary; and

8 (B) no payment shall be made to satellite
9 facilities of certified community behavioral
10 health clinics if such facilities are established
11 after the date of enactment of this Act.

12 (c) PLANNING GRANTS.—

13 (1) IN GENERAL.—Not later than January 1,
14 2016, the Secretary shall award planning grants to
15 States for the purpose of developing proposals to
16 participate in time-limited demonstration programs
17 described in subsection (d).

18 (2) USE OF FUNDS.—A State awarded a plan-
19 ning grant under this subsection shall—

20 (A) solicit input with respect to the devel-
21 opment of such a demonstration program from
22 patients, providers, and other stakeholders;

23 (B) certify clinics as certified community
24 behavioral health clinics for purposes of partici-

1 pating in a demonstration program conducted
2 under subsection (d); and

3 (C) establish a prospective payment system
4 for mental health services furnished by a cer-
5 tified community behavioral health clinic par-
6 ticipating in a demonstration program under
7 subsection (d) in accordance with the guidance
8 issued under subsection (b).

9 (d) DEMONSTRATION PROGRAMS.—

10 (1) IN GENERAL.—Not later than September 1,
11 2017, the Secretary shall select States to participate
12 in demonstration programs that are developed
13 through planning grants awarded under subsection
14 (c), meet the requirements of this subsection, and
15 represent a diverse selection of geographic areas, in-
16 cluding rural and underserved areas.

17 (2) APPLICATION REQUIREMENTS.—

18 (A) IN GENERAL.—The Secretary shall so-
19 licit applications to participate in demonstration
20 programs under this subsection solely from
21 States awarded planning grants under sub-
22 section (c).

23 (B) REQUIRED INFORMATION.—An appli-
24 cation for a demonstration program under this
25 subsection shall include the following:

1 (i) The target Medicaid population to
2 be served under the demonstration pro-
3 gram.

4 (ii) A list of participating certified
5 community behavioral health clinics.

6 (iii) Verification that the State has
7 certified a participating clinic as a certified
8 community behavioral health clinic in ac-
9 cordance with the requirements of sub-
10 section (b).

11 (iv) A description of the scope of the
12 mental health services available under the
13 State Medicaid program that will be paid
14 for under the prospective payment system
15 tested in the demonstration program.

16 (v) Verification that the State has
17 agreed to pay for such services at the rate
18 established under the prospective payment
19 system.

20 (vi) Such other information as the
21 Secretary may require relating to the dem-
22 onstration program including with respect
23 to determining the soundness of the pro-
24 posed prospective payment system.

1 (3) NUMBER AND LENGTH OF DEMONSTRATION
2 PROGRAMS.—Not more than 8 States shall be se-
3 lected for 2-year demonstration programs under this
4 subsection.

5 (4) REQUIREMENTS FOR SELECTING DEM-
6 ONSTRATION PROGRAMS.—

7 (A) IN GENERAL.—The Secretary shall
8 give preference to selecting demonstration pro-
9 grams where participating certified community
10 behavioral health clinics—

11 (i) provide the most complete scope of
12 services described in subsection (a)(2)(D)
13 to individuals eligible for medical assist-
14 ance under the State Medicaid program;

15 (ii) will improve availability of, access
16 to, and participation in, services described
17 in subsection (a)(2)(D) to individuals eligi-
18 ble for medical assistance under the State
19 Medicaid program;

20 (iii) will improve availability of, access
21 to, and participation in assisted outpatient
22 mental health treatment in the State; or

23 (iv) demonstrate the potential to ex-
24 pand available mental health services in a
25 demonstration area and increase the qual-

1 ity of such services without increasing net
2 Federal spending.

3 (5) PAYMENT FOR MEDICAL ASSISTANCE FOR
4 MENTAL HEALTH SERVICES PROVIDED BY CER-
5 TIFIED COMMUNITY BEHAVIORAL HEALTH CLIN-
6 ICS.—

7 (A) IN GENERAL.—The Secretary shall pay
8 a State participating in a demonstration pro-
9 gram under this subsection the Federal match-
10 ing percentage specified in subparagraph (B)
11 for amounts expended by the State to provide
12 medical assistance for mental health services
13 described in the demonstration program appli-
14 cation in accordance with paragraph (2)(B)(iv)
15 that are provided by certified community behav-
16 ioral health clinics to individuals who are en-
17 rolled in the State Medicaid program. Payments
18 to States made under this paragraph shall be
19 considered to have been under, and are subject
20 to the requirements of, section 1903 of the So-
21 cial Security Act (42 U.S.C. 1396b).

22 (B) FEDERAL MATCHING PERCENTAGE.—
23 The Federal matching percentage specified in
24 this subparagraph is with respect to medical as-

1 assistance described in subparagraph (A) that is
2 furnished—

3 (i) to a newly eligible individual de-
4 scribed in paragraph (2) of section 1905(y)
5 of the Social Security Act (42 U.S.C.
6 1396d(y)), the matching rate applicable
7 under paragraph (1) of that section; and

8 (ii) to an individual who is not a
9 newly eligible individual (as so described)
10 but who is eligible for medical assistance
11 under the State Medicaid program, the en-
12 hanced FMAP applicable to the State.

13 (C) LIMITATIONS.—

14 (i) IN GENERAL.—Payments shall be
15 made under this paragraph to a State only
16 for mental health services—

17 (I) that are described in the dem-
18 onstration program application in ac-
19 cordance with paragraph (2)(iv);

20 (II) for which payment is avail-
21 able under the State Medicaid pro-
22 gram; and

23 (III) that are provided to an indi-
24 vidual who is eligible for medical as-

1 sistance under the State Medicaid
2 program.

3 (ii) PROHIBITED PAYMENTS.—No
4 payment shall be made under this para-
5 graph—

6 (I) for inpatient care, residential
7 treatment, room and board expenses,
8 or any other non-ambulatory services,
9 as determined by the Secretary; or

10 (II) with respect to payments
11 made to satellite facilities of certified
12 community behavioral health clinics if
13 such facilities are established after the
14 date of enactment of this Act.

15 (6) WAIVER OF STATEWIDENESS REQUIRE-
16 MENT.—The Secretary shall waive section
17 1902(a)(1) of the Social Security Act (42 U.S.C.
18 1396a(a)(1)) (relating to statewideness) as may be
19 necessary to conduct demonstration programs in ac-
20 cordance with the requirements of this subsection.

21 (7) ANNUAL REPORTS.—

22 (A) IN GENERAL.—Not later than 1 year
23 after the date on which the first State is se-
24 lected for a demonstration program under this
25 subsection, and annually thereafter, the Sec-

1 retary shall submit to Congress an annual re-
2 port on the use of funds provided under all
3 demonstration programs conducted under this
4 subsection. Each such report shall include—

5 (i) an assessment of access to commu-
6 nity-based mental health services under the
7 Medicaid program in the area or areas of
8 a State targeted by a demonstration pro-
9 gram compared to other areas of the State;

10 (ii) an assessment of the quality and
11 scope of services provided by certified com-
12 munity behavioral health clinics compared
13 to community-based mental health services
14 provided in States not participating in a
15 demonstration program under this sub-
16 section and in areas of a demonstration
17 State that are not participating in the
18 demonstration program; and

19 (iii) an assessment of the impact of
20 the demonstration programs on the Fed-
21 eral and State costs of a full range of men-
22 tal health services (including inpatient,
23 emergency and ambulatory services).

24 (B) RECOMMENDATIONS.—Not later than
25 December 31, 2021, the Secretary shall submit

1 to Congress recommendations concerning
2 whether the demonstration programs under this
3 section should be continued, expanded, modi-
4 fied, or terminated.

5 (e) DEFINITIONS.—In this section:

6 (1) FEDERALLY-QUALIFIED HEALTH CENTER
7 SERVICES; FEDERALLY-QUALIFIED HEALTH CENTER;
8 RURAL HEALTH CLINIC SERVICES; RURAL HEALTH
9 CLINIC.—The terms “Federally-qualified health cen-
10 ter services”, “Federally-qualified health center”,
11 “rural health clinic services”, and “rural health clin-
12 ic” have the meanings given those terms in section
13 1905(l) of the Social Security Act (42 U.S.C.
14 1396d(l)).

15 (2) ENHANCED FMAP.—The term “enhanced
16 FMAP” has the meaning given that term in section
17 2105(b) of the Social Security Act (42 U.S.C.
18 1397dd(b)) but without regard to the second and
19 third sentences of that section.

20 (3) SECRETARY.—The term “Secretary” means
21 the Secretary of Health and Human Services.

22 (4) STATE.—The term “State” has the mean-
23 ing given such term for purposes of title XIX of the
24 Social Security Act (42 U.S.C. 1396 et seq.).

25 (f) FUNDING.—

1 (1) IN GENERAL.—Out of any funds in the
2 Treasury not otherwise appropriated, there is appro-
3 priated to the Secretary—

4 (A) for purposes of carrying out sub-
5 sections (a), (b), and (d)(7), \$2,000,000 for fis-
6 cal year 2014; and

7 (B) for purposes of awarding planning
8 grants under subsection (c), \$25,000,000 for
9 fiscal year 2016.

10 (2) AVAILABILITY.—Funds appropriated under
11 paragraph (1) shall remain available until expended.

12 **SEC. 224. ASSISTED OUTPATIENT TREATMENT GRANT PRO-**
13 **GRAM FOR INDIVIDUALS WITH SERIOUS MEN-**
14 **TAL ILLNESS.**

15 (a) IN GENERAL.—The Secretary shall establish a 4-
16 year pilot program to award not more than 50 grants each
17 year to eligible entities for assisted outpatient treatment
18 programs for individuals with serious mental illness.

19 (b) CONSULTATION.—The Secretary shall carry out
20 this section in consultation with the Director of the Na-
21 tional Institute of Mental Health, the Attorney General
22 of the United States, the Administrator of the Administra-
23 tion for Community Living, and the Administrator of the
24 Substance Abuse and Mental Health Services Administra-
25 tion.

1 (c) SELECTING AMONG APPLICANTS.—The Sec-
2 retary—

3 (1) may only award grants under this section to
4 applicants that have not previously implemented an
5 assisted outpatient treatment program; and

6 (2) shall evaluate applicants based on their po-
7 tential to reduce hospitalization, homelessness, incar-
8 ceration, and interaction with the criminal justice
9 system while improving the health and social out-
10 comes of the patient.

11 (d) USE OF GRANT.—An assisted outpatient treat-
12 ment program funded with a grant awarded under this
13 section shall include—

14 (1) evaluating the medical and social needs of
15 the patients who are participating in the program;

16 (2) preparing and executing treatment plans for
17 such patients that—

18 (A) include criteria for completion of
19 court-ordered treatment; and

20 (B) provide for monitoring of the patient's
21 compliance with the treatment plan, including
22 compliance with medication and other treat-
23 ment regimens;

24 (3) providing for such patients case manage-
25 ment services that support the treatment plan;

1 (4) ensuring appropriate referrals to medical
2 and social service providers;

3 (5) evaluating the process for implementing the
4 program to ensure consistency with the patient's
5 needs and State law; and

6 (6) measuring treatment outcomes, including
7 health and social outcomes such as rates of incarcer-
8 ation, health care utilization, and homelessness.

9 (e) REPORT.—Not later than the end of each of fiscal
10 years 2016, 2017, and 2018, the Secretary shall submit
11 a report to the appropriate congressional committees on
12 the grant program under this section. Each such report
13 shall include an evaluation of the following:

14 (1) Cost savings and public health outcomes
15 such as mortality, suicide, substance abuse, hos-
16 pitalization, and use of services.

17 (2) Rates of incarceration by patients.

18 (3) Rates of homelessness among patients.

19 (4) Patient and family satisfaction with pro-
20 gram participation.

21 (f) DEFINITIONS.—In this section:

22 (1) The term “assisted outpatient treatment”
23 means medically prescribed mental health treatment
24 that a patient receives while living in a community

1 under the terms of a law authorizing a State or local
2 court to order such treatment.

3 (2) The term “eligible entity” means a county,
4 city, mental health system, mental health court, or
5 any other entity with authority under the law of the
6 State in which the grantee is located to implement,
7 monitor, and oversee assisted outpatient treatment
8 programs.

9 (3) The term “Secretary” means the Secretary
10 of Health and Human Services.

11 (g) FUNDING.—

12 (1) AMOUNT OF GRANTS.—A grant under this
13 section shall be in an amount that is not more than
14 \$1,000,000 for each of fiscal years 2015 through
15 2018. Subject to the preceding sentence, the Sec-
16 retary shall determine the amount of each grant
17 based on the population of the area, including esti-
18 mated patients, to be served under the grant.

19 (2) AUTHORIZATION OF APPROPRIATIONS.—

20 There is authorized to be appropriated to carry out
21 this section \$15,000,000 for each of fiscal years
22 2015 through 2018.

23 **SEC. 225. EXCLUSION FROM PAYGO SCORECARDS.**

24 (a) STATUTORY PAY-AS-YOU-GO SCORECARDS.—The
25 budgetary effects of this Act shall not be entered on either

1 PAYGO scorecard maintained pursuant to section 4(d) of
2 the Statutory Pay-As-You-Go Act of 2010.

3 (b) SENATE PAYGO SCORECARDS.—The budgetary
4 effects of this Act shall not be entered on any PAYGO
5 scorecard maintained for purposes of section 201 of S.
6 Con. Res. 21 (110th Congress).

Passed the House of Representatives March 27,
2014.

Attest:

KAREN L. HAAS,
Clerk.